

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15 (4)
30M REV. 11-68

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH
00001

1. DECEASED-NAME (Type or print) First Middle Last EDITH MAE AIRHART			2a. DATE OF DEATH Month Day Year JANUARY 15, 1969			2b. HOUR 11:00							
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JULY 18, 1900		6. AGE (In years last birthday) 68 YRS.		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) MAGNOLIA, W.VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.							
10. CITY OR TOWN OF DEATH FROSTBURG			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 75 EAST MAIN STREET			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY OWN HOME				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 75 E. MAIN STREET				
14. FATHER'S NAME First Middle Last HENRY KASECAMP			15. MOTHER'S MAIDEN NAME First Middle Last RUTH TWIGG										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) N.A.			16b. SOCIAL SECURITY NO. 218-07-9613D		17. INFORMANT FROSTBURG, MD. MRS. ARTHUR FEMI MORANTOWN, R.F.D.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week - years -													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State			
22a. I certify that (I) (this hospital) attended the deceased from Dec, 1968, to Jan 15, 1969, that (I) (we) last saw the deceased alive on 1/15/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE John B. Davis			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/17/69-	
22d. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M.D.			22e. ADDRESS 2 BROADWAY, FROSTBURG, MARYLAND										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 1/18/69		23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY		23d. LOCATION (City or Town) (County) (State) ECKHART ALLEGANY, MD.						
24. FUNERAL DIRECTOR M. SOWERS HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG			25a. REC'D BY REGISTRAR DATE 1/23/1969			25b. REGISTRAR'S SIGNATURE Charles Judge							

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FOR POLICE USE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last Estella Balsley						2a. DATE OF DEATH at 11:50 PM Month Day Year January 12, 1969			2b. HOUR P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 6/29/1871		6. AGE (In years last birthday) 97 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany County Md.					
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 129 Mary Street	
14. FATHER'S NAME First Middle Last Richard Balsley				15. MOTHER'S MAIDEN NAME First Middle Last Charity Diddle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 218-12-3228			17. INFORMANT P.O. Box 599, Cumberland, Md.			Address Allegany County Infirmary records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 4121 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chl. ASAB with hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days many years many years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from July 14, 1967 to Jan. 12, 1969 , that (I) (we) last saw the deceased alive on Jan. 11, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John A. Lipper</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-13-69			
22d. PHYSICIAN'S NAME (Type) <i>John A. Lipper MD</i>						22e. ADDRESS Memorial Hospital, Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 15, 1969		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						ADDRESS		25a. REC'D BY REGISTRAR JAN 16 1969		25b. REGISTRAR'S SIGNATURE <i>William A. Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
00003									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Jessie June Barkman						January 24, 1969		5.10P	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Female		White		June 12, 1890		78 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Allegany, Cumberland, Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		413 Pulaski Street		Housekeeper -At Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Allegany		Cumberland				413 Pulaski St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
James Oliver Hinkle			Susan Virginia Willison						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		217-18-4534		Mrs. Ruth Browning		413 Pulaski St Cumberland, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>								7 days	
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Hypertensive cardiovascular disease</u>								20 yrs.	
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Diabetes mellitus</u>								20 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
<u>Generalized arteriosclerosis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
none		none		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19		None					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		None							
22a. I certify that (I) (this hospital) attended the deceased from Jan. 19, 1968, to Jan. 24, 1969, that (I) (we) last saw the deceased alive on Jan. 24, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 5.10 P.M.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
James P. Hallinan M.D.								Jan. 25, 1969	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
James P. Hallinan M. D.				140 Bedford St., Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/27/69		Rose Hill Cemetery		Cumberland Allegany Maryland			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Silcox-Merritt Funeral Service				Cumberland, Md.		DATE JAN 27 1969		Richard Jones	

Éditions

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last EVA M. BEEMAN						2a. DATE OF DEATH Month Day Year 1/29/1969			2b. HOUR 8:45 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3/1/1903			6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany Md.					
10. CITY OR TOWN OF DEATH Frostburg			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miners Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House wife			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY Allegany		13c. CITY OR TOWN Midland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER None			
14. FATHER'S NAME First Middle Last George H. Stevenson				15. MOTHER'S MAIDEN NAME First Middle Last Sarah E. Winters								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO. NONE		17. INFORMANT Clinton Beeman			Address Midland, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H C U D C Cerebral accident 4122 DUE TO, OR AS A CONSEQUENCE OF (b) repeated cerebral accidents years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Jan 15 , 19 69 , to Jan 29 19 69 , that (I) (we) last saw the deceased alive on Jan 29 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE John B. Davis						DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/30/69		
22d. PHYSICIAN'S NAME (Type) John B. Davis						22e. ADDRESS Frostburg, Md. 21532						
23a. BURIAL, CREMATION, BENOWAL (Specify) Burial		23b. DATE 2/1/1969		23c. NAME OF CEMETERY OR CREMATORY Memorial Park				23d. LOCATION (City or Town) (County) (State) Frostburg, Md.				
24. FUNERAL DIRECTOR George Eichhorn				ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR FEB 3 1969		25b. REGISTRAR'S SIGNATURE [Signature]				

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
00005 Item 23 Film 409 1/29/69 kk CERTIFICATE OF DEATH 00005										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
DEANA			W. BITTINGER			Month 1 Day 10 Year 69		2:30 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
FEMALE		WHITE		5-30-68		7. YRS. 7		IF UNDER 24 HRS. MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
PENNSYLVANIA		U.S.A.				ALLEGANY				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND		MEMORIAL HOSPITAL								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
PENNA.				MEYERSDALE				RT. 4		
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last	
HERMAN			BITTINGER			CATHERINE			BEEMAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT		Address		
						MEMORIAL HOSPITAL		CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Pneumonia, fulminating</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) _____										
DUE TO, OR AS A CONSEQUENCE OF										
(c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<u>Downs Syndrome - Cong Heart Disease</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>1/3</u> , 19 <u>69</u> , to <u>1/10</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/10</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Robert J. Dawson</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/13/69</u>			
22d. PHYSICIAN'S NAME (Type) DR. ROBERT J. DAWSON					22e. ADDRESS CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		1/13/1969		St. John's Cemetery		Meyersdale Som. Pennsylvania				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
William C. Price Fun. Home, Meyersdale, Penna.					JAN 22 1969		<u>Charles Judge</u>			

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DEATH 10 09 2:30P

FEMALE WHITE 3-30-00 PENNSYLVANIA U.S.A. ALLEGANY

CUMBERLAND HENNA. MEYERSDALE X RY. 4

HERMAN BITTINGER CATHERINE DEEMER MEMORIAL HOSPITAL CUMBERLAND, MD.

DR. ROBERT J. DAVISON CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.)

VR A15 (4)
45M - 1-69

00006		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00006	
CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR M
HARRY		C.		BROOKS	JANUARY 1 69		38
3 SEX MALE		4 RACE WHITE Colored		5 DATE OF BIRTH 5/7/98		6 AGE (In years last birthday) 70 YRS	
7a BIRTHPLACE (State or foreign country) W. VA.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY	
10 CITY OR TOWN OF DEATH CUMBERLAND		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital) MEMORIAL HOSPITAL		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased admission) STATE MD.		13b COUNTY ALLEGANY		13c CITY OR TOWN CUMBERLAND		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last JOSEPH BROOKS		15. MOTHER'S MAIDEN NAME First Middle Last BELL BRADY		13e STREET AND NUMBER 104 MECHANIC ST.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 214-05-5271		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a) <u>storing the underlying cause last.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/4/69</u> to <u>12/4/69</u> that (I) (we) last saw the deceased alive on <u>12/4/69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Blane M. Schindler</u>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/14/69	
22d. PHYSICIAN'S NAME (Type) BLANE M. SCHINDLER, M.D.		22e. ADDRESS 43 GREENE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/4/69		23c. NAME OF CEMETERY OR CREMATORY Romney		23d. LOCATION (City or Town) (County) (State) Romney Hampshire W. Va.	
24. FUNERAL DIRECTOR <u>Shaffer</u>		ADDRESS ROMNEY, W. VA.		25a. REG. BY REGISTRAR JAN 8 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First Mattie		Middle Campbell		Last Campbell		2a DATE OF DEATH Month ⁶⁹ Day 15 Year 1968	2b HOUR 240P ^M
3 SEX Female		4 RACE Negro		5. DATE OF BIRTH 7-15-82			6 AGE (In years last birthday) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? Allegany, USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany		Md.		
10. CITY OR TOWN OF DEATH Cumberland		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cumberland Nursing Center		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Hotel Hammersmith		12b. KIND OF BUSINESS OR INDUSTRY Hotel				
13a USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. if institution Residence before 13c COUNTY Allegany		13c CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Kennedy Homes Apt. 305		
14. FATHER'S NAME First Edward Middle Williams			15. MOTHER'S MAIDEN NAME First Middle Adams			Last ADAMS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give war or dates of service)		16b SOCIAL SECURITY NO 206-03-5444		17 INFORMANT Mrs. George Ashby		Address 320 Central Ave. Cumberland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1 DEATH WAS CAUSED BY										
IMMEDIATE CAUSE (a) <u>myoplectic stroke</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>hypertension</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>arteriosclerosis, diabetes</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>1-2-69</u> , to <u>1-15-69</u> , that (I) (we) last saw the deceased alive on <u>1-14-69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>E. Krings</u>				DEGREE ATTENDING PHYS		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>1-15-69</u>		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
23a BURLIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE <u>1/18/1969</u>		23c NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d LOCATION (City or Town) Cumberland		(County) (State) Alleg Md		
24. FUNERAL DIRECTOR <u>John J. Hafer</u>				25a. REC'D BY REGISTRAR JAN 20 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #23a Film #G408 1/22/69 vmp CERTIFICATE OF DEATH 00008									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Edwin			Howard			1 Month 14 Day 69 Year			6:30 P. M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
M		W.		2/28/1890		78 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
118		U.S.				311 glory Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Cumberland			Hawking Home Cumberland Consolidated and			Retired			BY 45
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before adm-ssion) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Allegany		LaVale Cumberland				319 Algonquin Hotel Baltimore Street
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
John A. Cupler			Bessie Meldrum						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
No			217-07-6120		Chet F. H. S. LaVale, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u>									2 weeks
DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic contracted kidneys</u>									1 1/2 hrs
DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis</u>									2 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>3-1-1962</u> , to <u>1-14-1969</u> , that (I) (we) last saw the deceased alive on <u>1-14-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
L. Mings						1-15-69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-18-69		Oak Hill Cemetery		Bradford, Pa. McKean Pa.			
24. FUNERAL DIRECTOR		ADDRESS		Md		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John W. Hafe, Jr.		230 Balto Ave. Cumberland				JAN 17 1969		Charles Judge	

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VR A15
45M - 1

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First CORDELLA		Middle E.		Last CARDER		2a DATE OF DEATH Month 10 Day 30 Year 1969		
3 SEX FEMALE			4 RACE WHITE		5. DATE OF BIRTH 7/24/93			6 AGE (In years Birth day) 75		2b HOUR 4:20A	
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH ALLEGANY				
10. CITY OR TOWN OF DEATH CUMBERLAND			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institut on admission) STATE MARYLAND			13b COUNTY ALLEGANY		13c CITY OR TOWN CUMBERLAND		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER RT. 3, BEDFORD RD.		
14 FATHER'S NAME First GEORGE			Middle LONG		Last MARY		15 MOTHER'S MAIDEN NAME First MARY			Middle HAYES	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO.		17 INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD.			Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cancer</u>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State <u>Guyh</u> <u>Repley</u> <u>MD</u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/17/69</u> , 19 <u>69</u> , to <u>1/30/69</u> , that (I) (we) last saw the deceased alive on <u>1/30/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Dr. R. J. Williams</u>			22c PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS			22d ADDRESS 122 S. CENTRE ST. CUMBERLAND, MD.			22e DATE SIGNED 1/31/69		
23a BURIAL, CREMATION REMOVAL (Specify) Burial			23b DATE Feb. 1, 1969		23c NAME OF CEMETERY OR CREMATORY St. Michael's Cath Cem.			23d LOCATION (City or Town) (County) (State) Frostburg, Alleg Md			
24 FUNERAL DIRECTOR John J. Hafer, Jr.			ADDRESS 230 Balto Ave. Cumberland			25a REGISTRY REGISTRAR FEB 3 1969			25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH		2b HOUR		
GRACE E. CASSEN						JANUARY 9, 1969		6:05PM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		
FEMALE		WHITE		6-18-94		74 YRS.		MONTHS DAYS HOURS MIN		
7d BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10		
MARYLAND		U. S. A.				ALLEGANY		Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
CUMBERLAND		MEMORIAL HOSPITAL		NONE		NONE				
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
MARYLAND		ALLEGANY		CUMBERLAND				SYLVAN RETREAT		
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME		First Middle Last		
UNKNOWN					CASSEN	EMMA		HILLEARY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT			Address	
NO			219 54 2096			MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u>									7 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Coronary Heart Failure</u>									14 days	
(c) <u>Arteriosclerotic Heart Disease</u>									yes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f LOCATION		Street or R.F.D. No		City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>11/5</u> , 19 <u>69</u> , to <u>11/9</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>11/9</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.										
22b SIGNATURE					DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
<u>George M. Simons</u>									11/9/69	
22d PHYSICIAN'S NAME (Type)					22e ADDRESS					
DR. GEORGE M. SIMONS					CUMBERLAND, MD.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
BURIAL		JAN. 12, 1969		ROSE HILL CEMETERY		CUMBERLAND, MD.				
24 FUNERAL DIRECTOR					ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
BYRON KIGHT					CUMBERLAND, MD.		JAN 16 1969		<u>James Judge</u>	



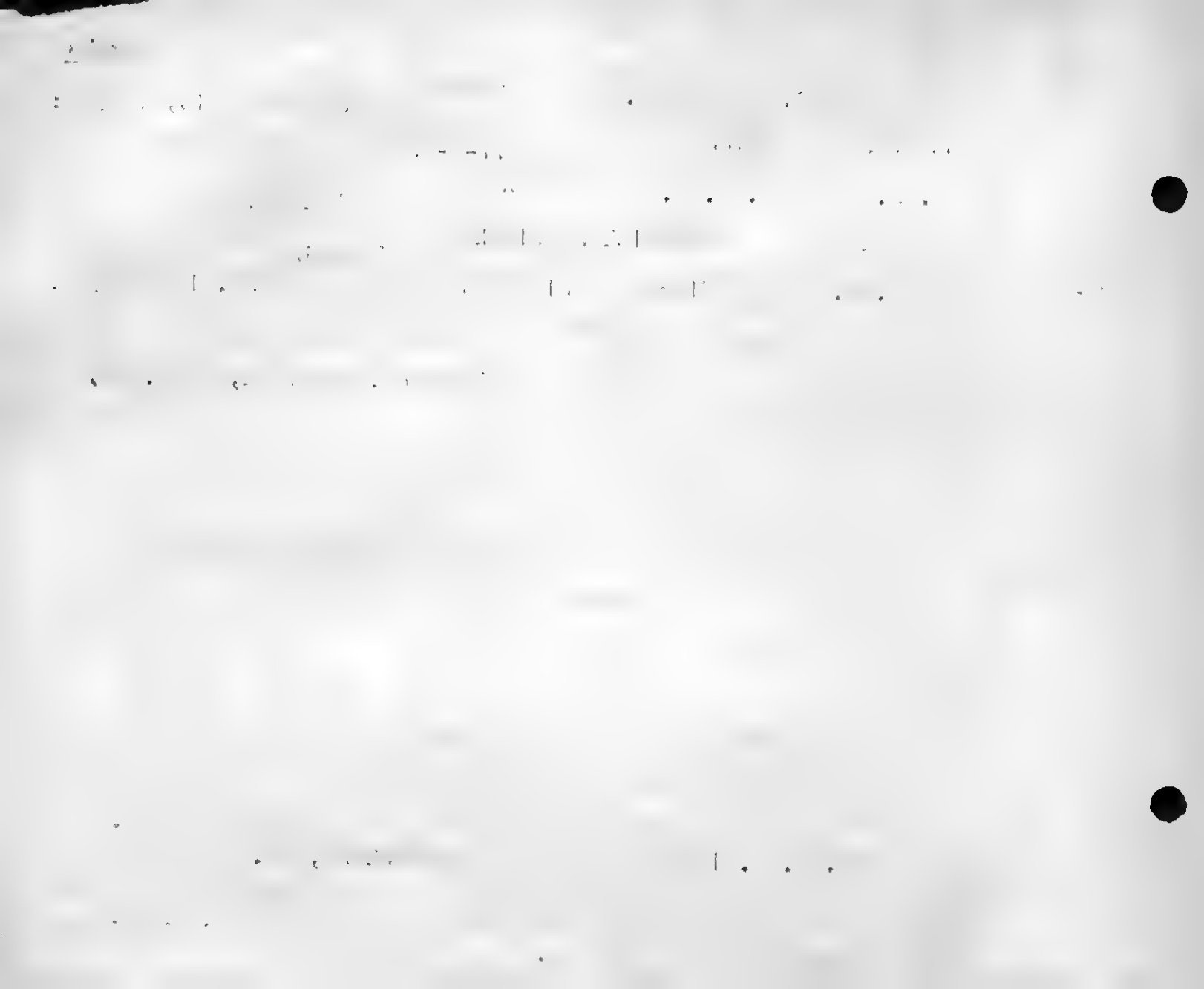
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month		2b. HOUR	
MARY VERONICA		TH		CHANEY				JANUARY 10, 1969		9:05 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years lost)		7. UNDER 1 YEAR MONTHS		7. UNDER 24 HRS HOURS MIN	
FEMALE		WHITE		11-6-1899		69 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
W. VA.		U. S. A.				ALLEGANY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		MEMORIAL HOSPITAL		HOUSEWIFE		OWN HOME					
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
W. VA.		MINERAL		RIDGELEY				RT. 1 BOX 352 A			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
WILLIAM		FLETCHER		HARVEY				KATHERINE ELLEN MURRAY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT				MEMORIAL HOSPITAL, CUMB. MD.			
NO											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asystole</u>										15 min	
4107 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial infarction</u>										8 days	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic heart disease</u>										yes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>1/2</u> , 19 <u>68</u> , to <u>1/10</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/10</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
<u>Dr. W. P. James</u>		1/11/69				DR. W. P. JAMES		CUMBERLAND, MD.			
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Jan. 13, 1969		Terra Alta Cemetery		Terra Alta W. Virginia					
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						25a. READ BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
						JAN 15 1969					
						DATE					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00012

00012

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year 1-20-69 12:20p M	
Thomas Aloysuis Collins						
3 SEX Male	4 RACE White	5 DATE OF BIRTH Mar. 11, 1916		6 AGE (in years) 52 YRS	2c DATE PRONOUNCED DEAD January 20, 1969 12:20p M	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Allegany Md	
10 CITY OR TOWN OF DEATH Cumberland		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dora Sacred Heart Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machinist helper		12b KIND OF BUSINESS OR INDUSTRY Textile
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Allegany		13c CITY OR TOWN Westernport	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e STREET AND NUMBER 249 Main	
14 FATHER'S NAME Thomas F Collins		15 MOTHER'S MAIDEN NAME Playgie Morgon				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) Yes		16b. SOCIAL SECURITY NO. W.W. 11 217-10-7245		17. INFORMANT ADDRESS Aleda Collins Westernport, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 4107 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CORONARY THROMBOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY SCLEROSIS</u> -----						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Benedict Skitarelic		M.D.		22b DATE SIGNED January 20, 1969		
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND		
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE 1/23/69		23c NAME OF CEMETERY OR CREMATORY St. Peters		23d LOCATION (City or Town) (County) (State) Westernport, Md.
24 FUNERAL DIRECTOR L. J. Boral		ADDRESS Westernport, Md.		25a REC'D BY REGISTRAR JAN 24 1969		25b REGISTRAR'S SIGNATURE Charles J. J...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) EDWARD First Middle Last Joseph CONWAY					2a. DATE OF DEATH Month 01 Day 20 Year 69		2b. HOUR 3:45 AM			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 06-19-06		6 AGE (In years last birthday) 62 YRS.		7 UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH ALLEGANY COUNTY, Md				
10 CITY OR TOWN OF DEATH CUMBERLAND			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) SALESMAN		12b BUSINESS OR INDUSTRY REINOLD LIQUORS, INC.		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b COUNTY ALLEGANY		13c CITY OR TOWN MT. SAVAGE		13d HOUSE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER BOX 451, MT. SAVAGE, MD.	
14 FATHER'S NAME First Middle Last JOSEPH CONWAY			15 MOTHER'S MAIDEN NAME First Middle Last (MC KENZIE) FLORENCE CONWAY							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no NO (If yes give war or dates of service)			16b SOCIAL SECURITY NO 214-05-5809		17 INFORMANT Address MD. 21502 SACRED HEART HOSPITAL-900 SETON DR., CUMB.,					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS 1574 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNK	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 1-19-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE L. Michael Glick DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c DATE SIGNED 1-20-69					
22d PHYSICIAN'S NAME (Type) L. MICHAEL GLICK					22e ADDRESS 126 N. SMALLWOOD ST CUMBERLAND					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DA 1/23/69		23c NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery		23d LOCATION (City or Town) (County) (State) Allegany, Cumberland, Md.				
24. FUNERAL DIRECTOR H. Wayne George ADDRESS MD. 21502 GEORGE FUNERAL HOME, 202 GREENE ST., CUMB.,					25a REC'D BY REGISTRAR JAN 27 1969 DATE		25b REGISTRAR'S SIGNATURE Charles J. [Signature]			

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Part II

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1. The first group of people who are interested in the study of the history of the United States are the people who are interested in the history of the United States.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR
JOHN CALVIN COOK						Month Day Year			llp M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c DATE PRONOUNCED DEAD	2d HOUR
MALE	WHITE	JULY 18, 1887	81 YRS	MONTHS	DAYS	HOURS	MIN	January 8, 1969	llp M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHICH COUNTRY?		8 MARRIED		9 COUNTY OF DEATH		MD	
Penns.		USA		W-DOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Allegany			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY
Cumberland			Memorial Hospital-DOA			Retired Brakeman			Railroad
13a USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Md.			Alle any		Rawlings	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 6	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Theodore Cook			Mary Ellen Tipton						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS				
no					Mrs. Regina Cook, Rawlings, Md.-Wife				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)									Sudden
4107 Coronary Occlusion									
DUE TO, OR AS A CONSEQUENCE OF									
Coronary Sclerosis									--
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. P.M. 19						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State				
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22a Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
Benedict Skitarelic			M.D.			January 6, 1969			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street city town, or county)			
BENEDICT SKITARELIC, M.D.			CUMBERLAND, MARYLAND						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		Jan. 9, 1969		Hyndman Cemetery		Hyndman, Penna.			
24 FUNERAL DIRECTOR			ADDRESS			25a RECEIVED BY REG. STRIP		25b RECEIVED BY NATAL	
James F. Scarpelli, Cumberland, Md.						JAN 9 1969			

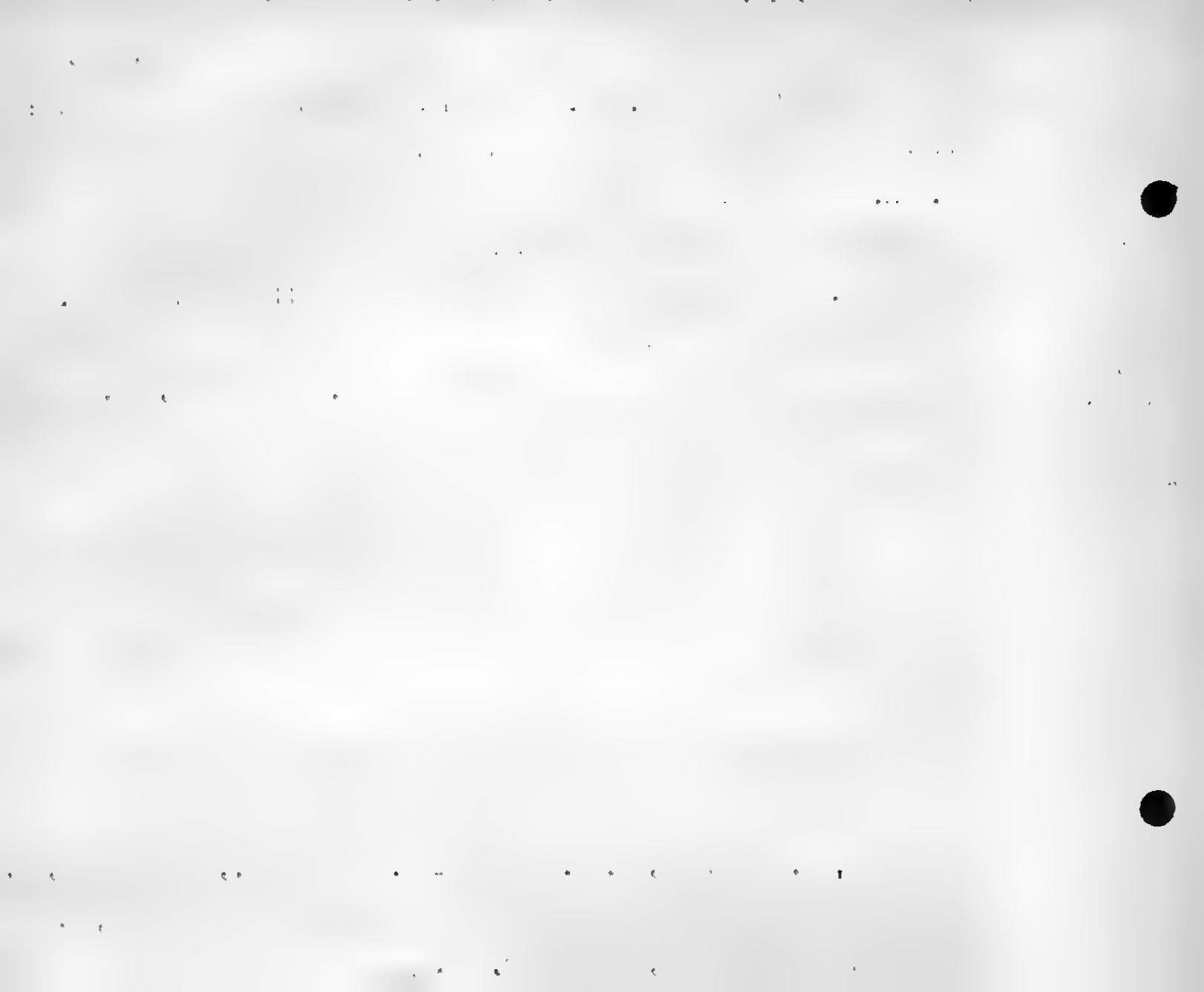


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers on pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/1969

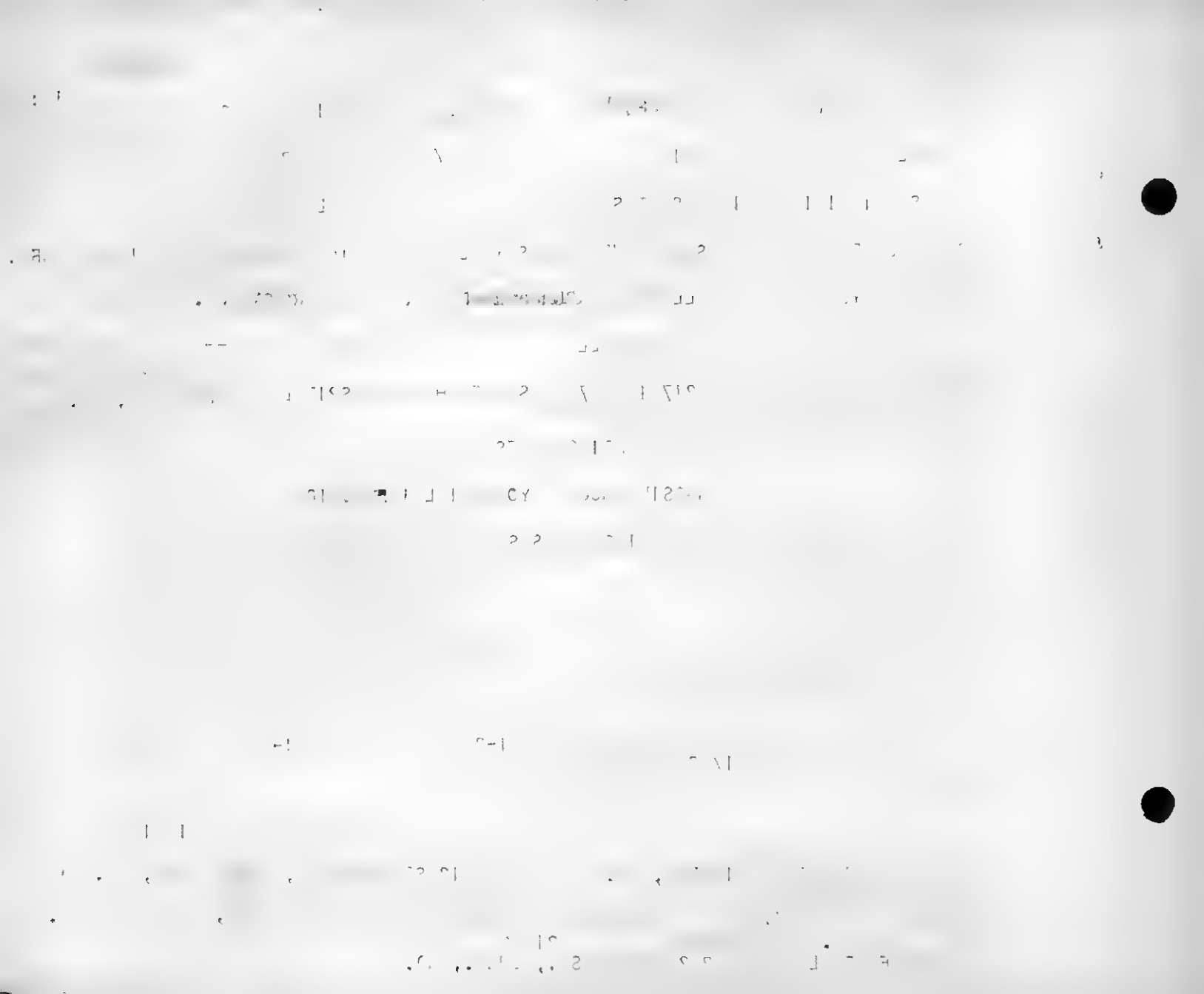
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First NELLIE		Middle G.		Last CRITES		2a DATE OF DEATH Month 6 Day 6 Year 69		2b HOUR 12:40	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 1-23-10		6 AGE (n years last birthday) 58 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 	
7a BIRTHPLACE (State or foreign country) W. VA.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH ALLEGANY					
10 CITY OR TOWN OF DEATH CUMBERLAND				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give name of place) MEMORIAL HOSPITAL				12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Associated With Husband's Transfer			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.		13b COUNTY ALLEGANY		13c CITY OR TOWN CUMBERLAND		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1114 MICHIGAN AVE.			
14 FATHER'S NAME First CALVIN Middle Last TURNER				15 MOTHER'S MAIDEN NAME First MYRTLE Middle Last GROVES							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 		17 INFORMANT MEMORIAL HOSP. CUMBERLAND, MD. Address 							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic adrenal Cortical 1940 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (Left) Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) 											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION 		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma as stated above				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) 				21f. LOCATION Street or RFD No. 		City or Town 		State 	
22a. I certify that (I) (this hospital) attended the deceased from 10-4-1968 to 1-6-1969 , that (I) (we) last saw the deceased alive on 1-5-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. F. Williams		22c. DATE SIGNED 1-6-69		22d. PHYSICIAN'S NAME (Type) W. F. WILLIAMS, M. D.							
22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 8, 1969		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME, CUMBERLAND, MD.				25a. REC'D BY REGISTRAR DATA 9		25b. REGISTRAR'S SIGNATURE James J. J...					



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15
45M 1869

20016		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00016	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print)		First Middle Last		2a DATE OF DEATH		2b HOUR MIN.	
WALTER HAROLD CUTCHALL				Month 30 Day 69 Year 1		12:50 PM	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 YRS
MALE	WHITE		6/20/98		70		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
WEST VIRGINIA		UNITED STATES				ALLEGANY Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		SACRED HEART HOSPITAL		TEXTILE Mechanic		CELANESE MFG.	
3a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MARYLAND		Chesapeake				Howard St.	
14 FATHER'S NAME First Middle Last		15 MOTHER'S MAIDEN NAME First Middle Last					
CURT CUTCHALL		Artima Cunningham					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown		16b SOCIAL SECURITY NO		17 INFORMANT Address			
NO		217 10 4973		SACRED HEART HOSPITAL		900 SETON DRIVE CUMBERLAND, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) MASSIVE ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour AM Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING ETC.)		21f LOCATION Street or RFD No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1-20, 1969, to 1-30, 1969, that (I) (we) last saw the deceased alive on 1/30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) view the body after death							
22b SIGNATURE Clarence Vincent M.D. DEGREE				22c DATE SIGNED 1/31/69			
22d PHYSICIAN'S NAME (Type) CLARENCE VINCENT, MD.				22e ADDRESS 912 SETON DRIVE, CUMBERLAND, MD. 21502			
23a BURIAL CREMATION, (Print or Type)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		2/2/1969		Restlawn Memorial Gardens		Cumberland, Allegany Md.	
24 FUNERAL DIRECTOR GEORGE FUNERAL HOME		ADDRESS 202 GREENE ST., CUMB.,		25a RECEIVED BY REGISTRAR DATE FEB 3 1969		25b REGISTRAR'S SIGNATURE H. Wayne George	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

00017										00017									
1 DECEASED-NAME (Type or print) First Middle Last GLADYS K. DANIELS										2a DATE OF DEATH Month Day Year JANUARY 15, 1969									
3 SEX FEMALE										4 RACE WHITE									
5 DATE OF BIRTH AUGUST 22, 1909										6 AGE (In years last birthday) YRS. 59									
7a BIRTHPLACE (State or foreign country) MARYLAND										7b. CITIZEN OF WHAT COUNTRY? USA									
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH ALLEGANY Md									
10 CITY OR TOWN OF DEATH CUMBERLAND										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACKED HEART HOSP.									
12a USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired) HOUSEWIFE										12b KIND OF BUSINESS OR INDUSTRY									
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND										13b COUNTY ALLEGANY									
13c CITY OR TOWN CUMBERLAND										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
13e STREET AND NUMBER 132 BEDFORD ST.																			
14. FATHER'S NAME First Middle Last HENRY TWIGG										15. MOTHER'S MAIDEN NAME First Middle Last (MORRISON) GERTRUDE TWIGG									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO										16b. SOCIAL SECURITY NO 214-09-8184									
17. INFORMANT HOSPITAL RECORD, 900 SETON DRIVE, CUMB., MD.										Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5609 DUE TO, OR AS A CONSEQUENCE OF MESENTERIC THROMBOSIS, EXTENSIVE (b) DUE TO, OR AS A CONSEQUENCE OF CONGESTIVE HEART FAILURE (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 3 DAYS 7 DAYS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) RHEUMATIC HEART DISEASE, CARDIOMEGALY, AURICULAR FIBRILLATION																			
19a. DATE OF OPERATION 1-14-69										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL OBSTRUCTION									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> NONE <input type="checkbox"/> OR CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. NONE Day Year P.M. 19									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B) NONE																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) NONE									
21f. LOCATION Street or R.F.D. No. City or Town County State AUG. 8, 57 JAN. 15, 69																			
22a. I certify that (I) (this hospital attendant) saw the deceased alive on AUG. 15, 19 57, and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE James P. Hallinan M.D.										22c. DATE SIGNED 1-17-69									
22d. PHYSICIAN'S NAME (Type) JAMES P. HALLINAN, M.D.										22e. ADDRESS 140 BEDFORD ST., CUMBERLAND, MD. 21502									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE 1/18/1969									
23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK										23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.									
24. FUNERAL DIRECTOR BYRON KIGHT										25a. REC'D BY REGISTRAR JAN 21 1969									
25b. REGISTRAR'S SIGNATURE Charles Judge																			

MEDICAL CERTIFICATION

1. The first part of the report

is devoted to a general survey

of the situation

in the various countries

concerned. The second part

contains a detailed analysis

of the economic and social

conditions in the

different regions.

The third part of the report

deals with the results of the

investigations.

The fourth part of the report

contains

concluding remarks.

1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

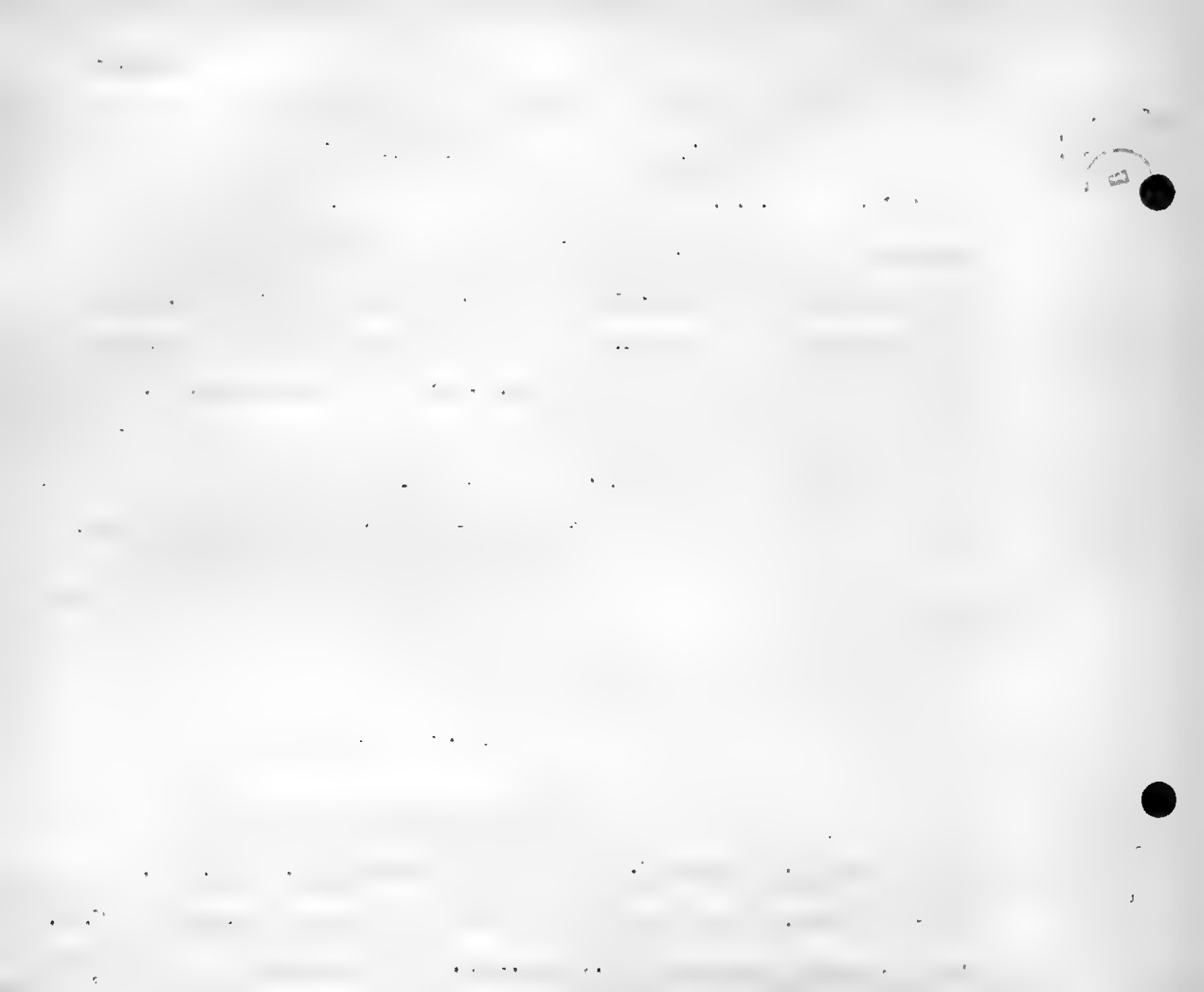
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00018

CERTIFICATE OF DEATH

00018

1. DECEASED-NAME (Type or print) PATIENCE GINN DANIELS			2a. DATE OF DEATH January 15 1969			2b. HOUR 8:23 PM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH February 10, 1875		6 AGE (in years last birthday) 93 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.			
10. CITY OR TOWN OF DEATH Cumberland		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 113 Grand Ave.	
14. FATHER'S NAME First Middle Last Samuel Ginn			15 MOTHER'S MAIDEN NAME First Middle Last ANNIE Annie Marker						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address Mrs. Edward Nield Cumberland, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Trauma 4123 DUE TO, OR AS A CONSEQUENCE OF (b) Myocarditis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs 3 yrs 10 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from June, 1950 to Jan 15, 1969 , that (I) (we) lost saw the deceased alive on Jan 12, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Clay E. Durrett DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c DATE SIGNED 1/17/69					
22d. PHYSICIAN'S NAME (Type) Clay E. Durrett, Md.				22e ADDRESS 236 Virginia Ave., Cumb., Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 18, 1969		23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery		23d. LOCATION (City or Town) (County) (State) Fort Ashby, Mineral, W.Va.			
24. FUNERAL DIRECTOR ADDRESS Philip B. Wendt 121 Memorial Ave., Cumb., Md.				25a. REC'D BY REGISTRAR JAN 20 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

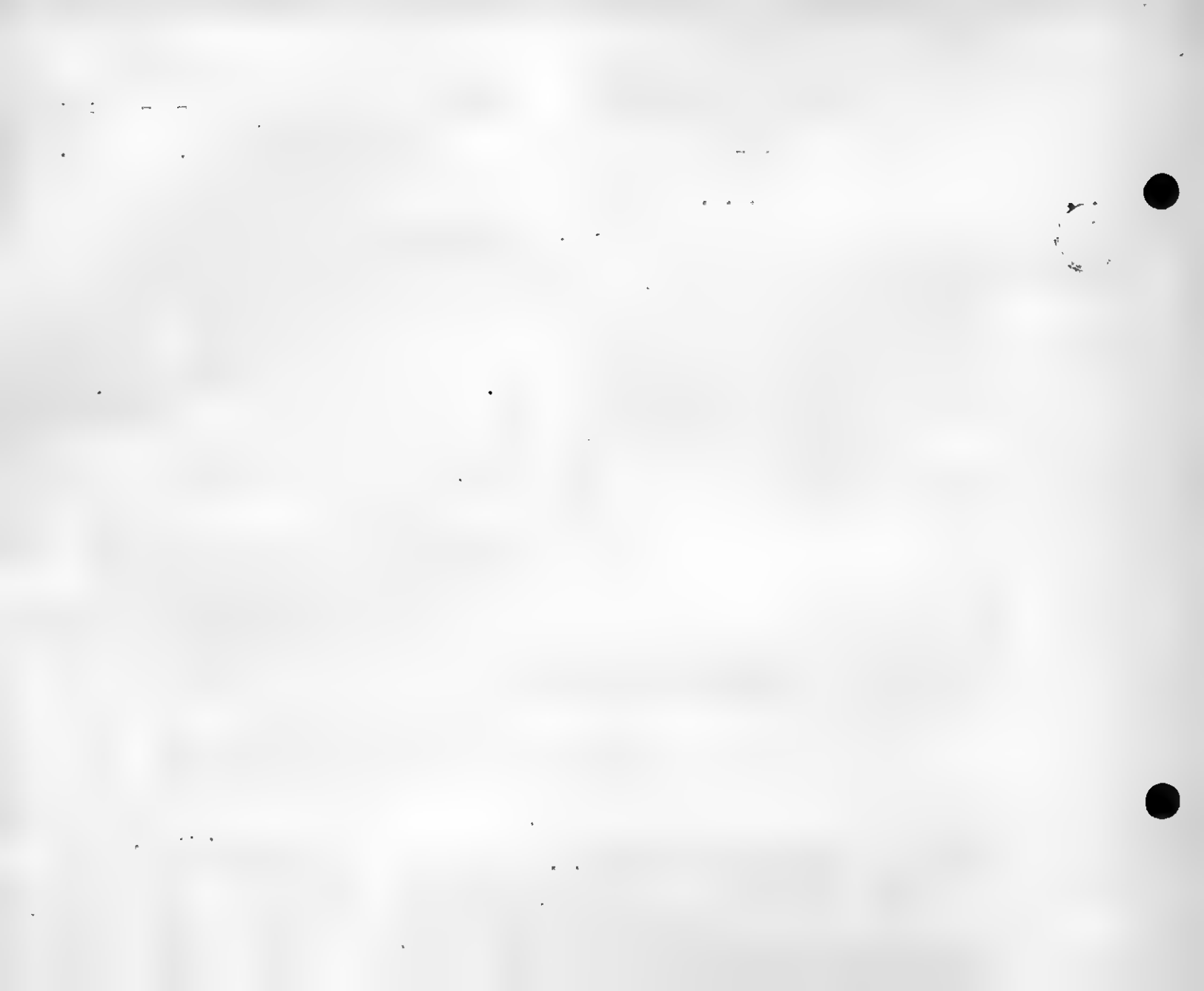


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH	
William		Lowdermilk		Darrow		2b. HOUR		2c. DATE ESTIMATED	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7c. DATE PRONOUNCED DEAD	
Male		White		1-9-1896		73 YRS		January 19, 1969	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		10. HOUR	
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Allegany		2.00p M	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET AND NUMBER	
Cumberland		822 Columbia Avenue		Retired Employee-		Celanese Corp		822 Columbia Avenue	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md		Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		822 Columbia Avenue	
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
Samuel		Darrow		Bessie		Ellen		Lowdermilk	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		18. CAUSE OF DEATH	
Yes		214-07-5823		Mrs. Janet Darrow		822 Columbia Ave		Cumberland, Md	
18. CAUSE OF DEATH (Enter only one cause per PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
153.0		December 1968		Carcinomatosis, Generalized		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6 Months	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
Primary Carcinoma of ascending colon		Primary Carcinoma of ascending colon		Primary Carcinoma of ascending colon		Primary Carcinoma of ascending colon		Primary Carcinoma of ascending colon	
with Lung Metastasis		with Lung Metastasis		with Lung Metastasis		with Lung Metastasis		with Lung Metastasis	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	
CAUSE OF DEATH		19		19		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. DATE SIGNED		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City or Town) (County) (State)		22e. FUNERAL DIRECTOR	
BENEDICT SKITARELIC, M.D.		January 19, 1969		Frostburg Memorial Park		Frostburg Allegany Maryland		1/22/69	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		23e. FUNERAL DIRECTOR	
Burial		1/22/69		Frostburg Memorial Park		Frostburg Allegany Maryland		1/22/69	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE	
Silcox-Merritt Funeral Service		Cumberland, Md		JAN 23 1969		Charles Judge		JAN 23 1969	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year	
HENRY L. DAVIS									01 03 69	
3 SEX		4. RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE		NEGRO		11-29-69			59 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
NORTH CAROLINA			U.S.A.				ALLEGANY COUNTY, Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. U.S.A. OCCUPATION (Kind of work done during last week or month, if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND			SACRED HEART HOSPITAL			TRUCK DRIVER			COAL CO.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY		CUMBERLAND				220 FULTON STREET	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
HENRY DAVIS			(LILLY) GRACE DAVIS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
NO			217-10-6809		SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,		MD. 21502			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>										3 days
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) <u></u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u></u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 31, 1968</u> , to <u>Jan 3, 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan 3, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Wayne C S Page</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c. DATE SIGNED <u>1-5-69</u>
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Jan 6, 1969		Woodlawn Cemetery			Cumberland Alleg		Md.
24. FUNERAL DIRECTOR <u>HAFFER FUNERAL HOME-230 BALTIMORE AVE., CUMB.,</u>					25a. REC'D BY REGISTRAR <u>MAN 8 1969</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Young</u>		

21

01

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(11-29-00)

11-29-00

11-29-00

11-29-00

11-29-00

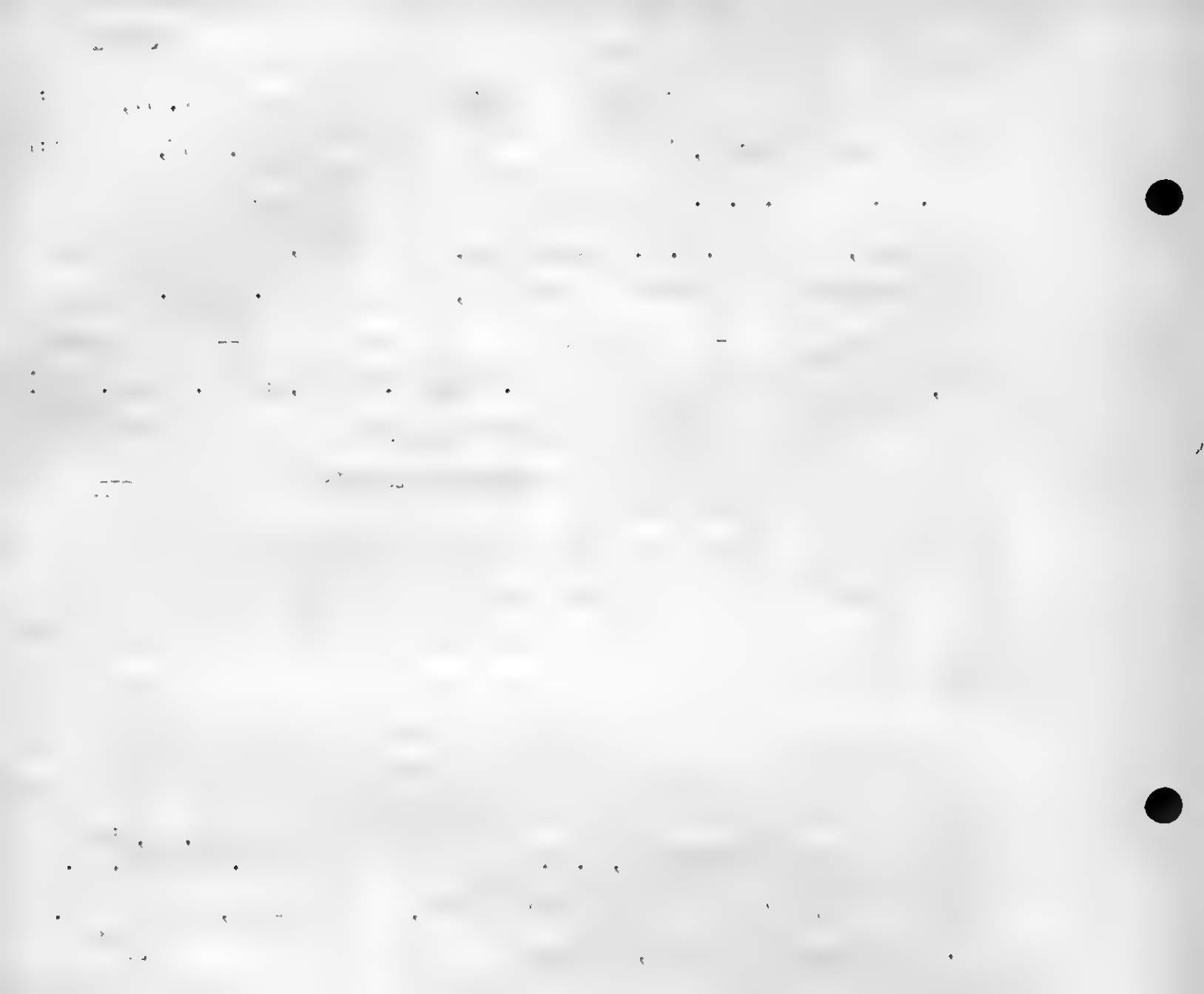
11-29-00

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form CMS-Page 5 may be returned for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Anna			Middle Brenice			Last Dawson		
3 SEX Female			4 RACE White		5 DATE OF BIRTH March 9, 1893		6 AGE (In years last birthday) 75 YRS.		7a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year Jan. 17, 1969		
7b BIRTHPLACE (State or foreign country) W. Va.			7c CITIZEN OF WHAT COUNTRY? U. S. A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			2b HOUR 5:15 P.M.		
10 CITY OR TOWN OF DEATH Cumberland,			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) D. O. A. Memorial Hosp.			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Housewife,			2d HOUR 5:15 P.M.		
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Allegany			13c CITY OR TOWN Cumberland,			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Jeff			Middle ---			Last Martenev			15 MOTHER'S MAIDEN NAME First Ida		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No,			16b SOCIAL SECURITY NO. None			17 INFORMANT Mr. Daniel M. Dawson, 207 So. Lee St. Cumb.			ADDRESS Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) --- DUE TO, OR AS A CONSEQUENCE OF (c) ---										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED Jan. 17, 1969			
EXAMINER'S NAME (Type) Benedict Skitarelic, M. D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) Rt. # 9 Cumb. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 1/20/69		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park,				23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland						25a. REC'D BY REGISTRAR DATE JAN 21 1969		25b. REGISTRAR'S SIGNATURE [Signature]			



CERTIFICATE OF DEATH

00022

00022

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
GEORGE			L.	DAY	JANUARY Month 3 Day 1969		3:45 M	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH 12-4-06		6 AGE (n years last birthday) 62		7 UNDER 1 YEAR MONTHS
7a BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		IF UNDER 24 HRS HOURS MIN
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital state where deceased died) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE W. VA.			13b. COUNTY PAW PAW		13c. CITY OR TOWN PAW PAW		13d. INSIDE CITY L.M.T? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER
14. FATHER'S NAME First Middle Last DAVID DAY			15. MOTHER'S MAIDEN NAME First Middle Last BERTIE MC DONALD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address MEMORIAL HOSP. CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>extensive coronary heart disease 16 years</i> 4125 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Chronic obstructive pulmonary disease</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>3 Jan</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3 Jan</u> , 19 <u>69</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Frederick Miltenberger</i>		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type) FREDERICK MILTENBERGER, M.D.		22e. ADDRESS 122 S. GREEN ST., CUMBERLAND, MD		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		1/6/1969		Camp Hill Cem.		Paw Paw (Morgan) W. Va.		
24. FUNERAL DIRECTOR <i>Johnson Funeral Home</i>		ADDRESS Berkeley Springs, W. Va.		25a. DEC'D BY REGISTRAR DATE JAN 8 1969		25b. REGISTRAR'S SIGNATURE <i>John H. H. H.</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VER 15 (4) 69

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First REGINA			Middle DELANEY			Last DELANEY		
2a. DATE OF DEATH			Month 4, Day 1969			2b. HOUR			M		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MARCH 1, 1905			6. AGE (In years lost birthday) 63 YRS		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.		
10. CITY OR TOWN OF DEATH FROSTBURG			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ROUTE 1			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CAFETERIA MANAGER			12b. KIND OF BUSINESS OR INDUSTRY SCHOOL		
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN FROSTBURG			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First WILLIAM			Middle S.			Last DELANEY			15. MOTHER'S MAIDEN NAME First RACHEL		
Middle KNIPPENBERG			Last KNIPPENBERG			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. 214-28-6534		
17. INFORMANT WM. P. DELANEY, FROSTBURG, MD.			Address 21532			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 mos 3 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>6-6-</u> , 19 <u>61</u> , to <u>1-4-</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1-2-</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Ralph W. Ballen</u>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 1-6-69		
22d. PHYSICIAN'S NAME (Type) RALPH W. BALLEN, M. D.			22e. ADDRESS 62 GREENE ST., CUMBERLAND, MD. 21502			23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE JAN. 7, 1969		
23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY			23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.			24. FUNERAL DIRECTOR J. R. DURST, FROSTBURG, MD.			25a. REC'D BY REGISTRAR JAN 8 1969		
25b. REGISTRAR'S SIGNATURE <u>Wm. H. Jones</u>											

MEDICAL CERTIFICATION

VR 3-4
JAN 17 1969

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

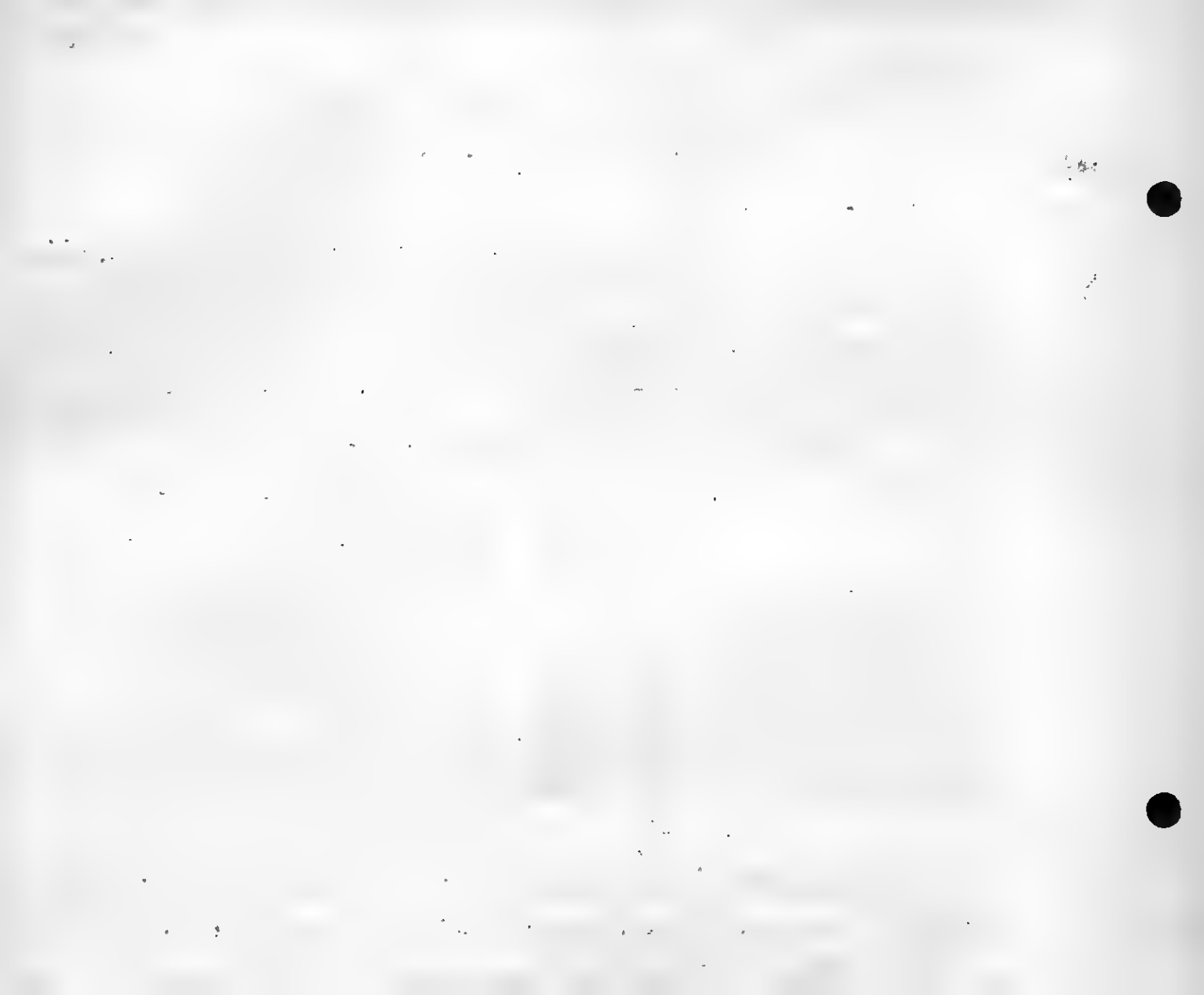
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00024

CERTIFICATE OF DEATH

00024

1. DECEASED NAME (Type or print) PHILIP		First PHILIP	Middle T.	Last DICKEL	2a. DATE OF DEATH JANUARY Month 26 , Day 1969		2b. HOUR AM	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH DEC. 15, 1908		6. AGE (in years last birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH FROSTBURG		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D O A MINERS HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) CONSTRUCTION		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN MT. SAVAGE		13d. INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ROUTE 1
14. FATHER'S NAME First CHARLES Middle E. Last DICKEL		15. MOTHER'S MAIDEN NAME First MARY Middle COLLINS Last COLLINS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 215-10-1258		17. INFORMANT Address ELMER L. DICKEL, MT. SAVAGE, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial failure, irreversible</u> 402X DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atrial flutter with complete heart block</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 3 weeks								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic nephritis with azotemia</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 4, 1969</u> , to <u>Jan 26, 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan 22, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>A. Paige Strong</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>Jan 26, 1969</u>		
22d. PHYSICIAN'S NAME (Type) A. PAIGE STRONG, M. D.				22e. ADDRESS E. MAIN ST., FROSTBURG, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JAN. 29, 1969		23c. NAME OF CEMETERY OR CREMATORY ST. PATRICK'S CEMETERY		23d. LOCATION (City or Town) (County) (State) MT. SAVAGE, MD.		
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532				25a. REC'D BY REGISTRAR DATE FEB 3 1969		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First ROXIE	Middle M.	Last DODGE	2a DATE OF DEATH 1 Month 26 Day 69 Year		2b HOUR 12:44 AM								
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH 1-23-99		6. AGE (In years lost birthday) 70 YRS.		F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN					
7a BIRTHPLACE (State or foreign country) PENNA.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md									
10 CITY OR TOWN OF DEATH CUMBERLAND		11 NAME OF HOSPITAL OR INSTITUTION (If not n hospital give street address) SACRED HEART HOSPITAL				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY							
13a USUAL RESIDENCE (Where deceased admission) STATE MD.		13b CITY OR TOWN ALLEGANY		13c CITY OR TOWN LA VALE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 10 ASBURY AVENUE							
14. FATHER'S NAME DANIEL		First DANIEL		Middle STULLER		Last (STELLAR)		15 MOTHER'S MAIDEN NAME MARGARET		First MARGARET		Middle STULLER		Last STULLER	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		(If yes give war or dates of service)		16b SOCIAL SECURITY NO 214-05-5606		17 INFORMANT HOSPITAL RECORDS		Address 900 SETON DR. CUMBERLAND, MD.							
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST 41 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY INSUFFICIENCY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) MYOCARDIAL FIBROSIS CORONARY ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 64 MIN. ?? ??															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS															
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med cal examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, OFF CE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State											
22a I certify that (I) (this hospital) attended the deceased from 9-14 , 19 68 , to 1-26 , 19 69 , that (I) (we) last saw the deceased alive on 1-26 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b SIGNATURE <i>S. G. Weisman</i>		22c DATE SIGNED 1-26-69		22d PHYSICIAN'S NAME (Type) S. G. WEISMAN, M.D.											
22e ADDRESS 59 GREENE ST., CUMBERLAND, MD.															
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 1/29/1969		23c NAME OF CEMETERY OR CREMATORY Crown Crest Memorial Park		23d LOCATION (City or Town) (County) (State) Clearfield (Clearfield) Penna.									
24 FUNERAL DIRECTOR <i>John H. Haffner</i>		24a ADDRESS Balto Ave Cumberland		24b Md.		25a REC'D BY REG STRAR Jan 29 1969		25b REG STRAR'S SIGNATURE <i>Charles Judge</i>							

5-11-1964

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(1) (2) (3)

DATE: 11-1-52

1, 7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Filing 1409 1/22/69 11w 00026									
CERTIFICATE OF DEATH									
00026									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
James			W. Duckworth Sr.			Jan 17 1969			4:20 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		Sept. 10, 1905		63		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
West Virginia		USA				Allegany County Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Cumberland			Allegany County Infirmary			Farming			Farming
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. den. before admission)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
West Virginia			Allegany			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1023 Shade's Lane	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
George Duckworth			Esther Travis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown) (If yes give year or dates of service))			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			220-10-2083		Mrs. Alice Toler, 1023 Shade's Lane				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Artery Disease</i>								<i>Not known</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Artery Disease</i>								<i>Not known</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Respiratory Paralysis of Unknown Origin</i>								<i>Not known</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Chronic Bronchitis - Acute Exacerbation, left following CVA '67.</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work									
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 9, 1969</i> to <i>Jan 17, 1969</i> , that (I) (we) last saw the deceased alive on <i>Jan 17, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
<i>John R. Tupper MD</i>								<i>Jan 18 1969</i>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
<i>John R. Tupper MD</i>									
23a. BURIAL CREMATION, (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		1/20/1969		Fort Ashby Cemetery		Fort Ashby, Mineral		W. Va.	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<i>Charles E. Harer</i>				230 Balto Ave. Cumberland		JAN 21 1969		<i>Charles E. Harer</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3002.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00027

1 DECEASED-NAME (Type or print) WILBUR			First Middle Last T. DURST			2a. DATE OF DEATH JANUARY Month 29 , Day 1969 Year			2b. HOUR M		
3 SEX MALE			4. RACE WHITE			5. DATE OF BIRTH JULY 15, 1887			6. AGE (In years lost birthday) 81 YRS.		
7a BIRTHPLACE (State or foreign country) MARYLAND			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH FROSTBURG			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED FATHER			12b KIND OF BUSINESS OR INDUSTRY OWN FARM		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c CITY OR TOWN FROSTBURG			13d INSIDE CITY LIM. TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER 300 E. MAIN STREET			14. FATHER'S NAME First Middle Last NORMAN DURST			15. MOTHER'S MAIDEN NAME First Middle Last ANNIE TURNER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown NO			16b SOCIAL SECURITY NO. 213-48-6856-T			17 INFORMANT ANNA C. DURST, FROSTBURG, MD.			Address 21532		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Ischemia DUE TO, OR AS A CONSEQUENCE OF Coronary Art. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos. years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I (this hospital) attended the deceased from 1964 , to Jan 29, 1969 , that we (we) last saw the deceased alive on Jan 28, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death.											
22b SIGNATURE Leslie R. Miles, M.D.						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 1-30-69		
22d. PHYSICIAN'S NAME (Type) LESLIE R. MILES, M. D.						22e. ADDRESS STATE ST., LONACONING, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE JAN. 31, 1969			23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY			23d. LOCATION (City or Town) (County) (State) GARRETT COUNTY, MD.		
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD.						ADDRESS 21532			25a REC'D BY REGISTRAR FEB 3 1969		
						25b. REGISTRAR'S SIGNATURE [Signature]					

00028

00028

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
ELMER			G.	FREELAND	JANUARY 3 1969		5:15 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 10-26-02		6. AGE (In years last birthday) 66 YRS.		7. UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) ALLEGANY		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired B & O Carman		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 912 MICHIGAN AVE.
14. FATHER'S NAME First Middle Last PHILIP G. FREELAND		15. MOTHER'S MAIDEN NAME First Middle Last SARAH A. MESSENGER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 705-07-9653		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma Lung</u> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Thrombosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 mon 2 mon 3 wks
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home farm street factory office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>Apr. 1968</u> to <u>Jan 3, 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan 3, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Clayton E. Durrett</u>		22c. DATE SIGNED 1/4/69		22d. PHYSICIAN'S NAME (Type) DR. C.E. DURRETT				
22e. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.								
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/6/69		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Mem Gardens		23d. LOCATION (City or Town) (County) (State) LaVale Allegany Maryland		
24. FUNERAL DIRECTOR ADDRESS Silcox-Merritt Funeral Service Cumberland, Md				25a. REC'D BY REGISTRAR JAN 7 1969		25b. REGISTRAR'S SIGNATURE <u>Charles J. Gage</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MR 813 41
JAN 14 1969

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

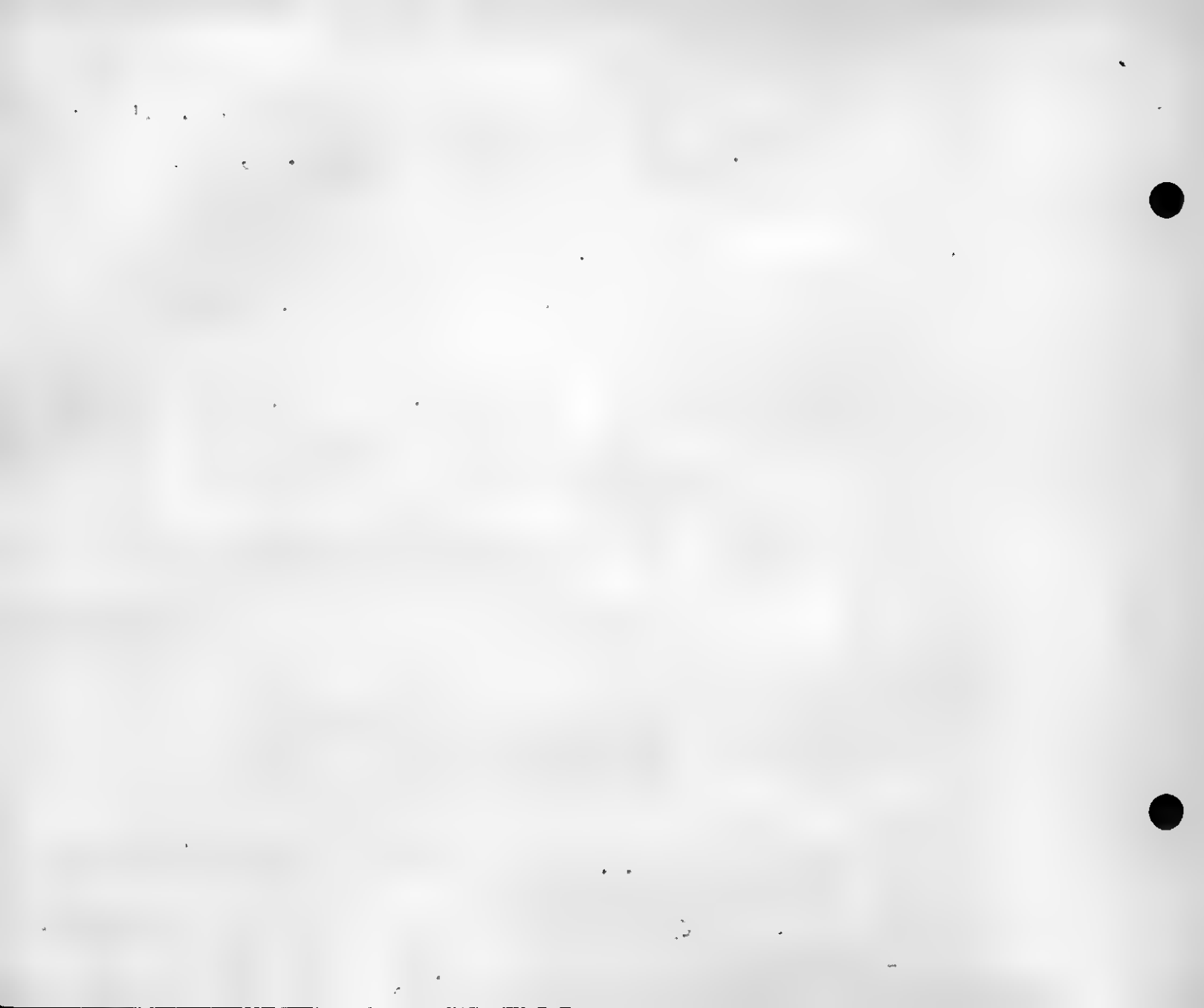
Items 18-22a Film 410 Maryland State Department of Health
3-7-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00029

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00029

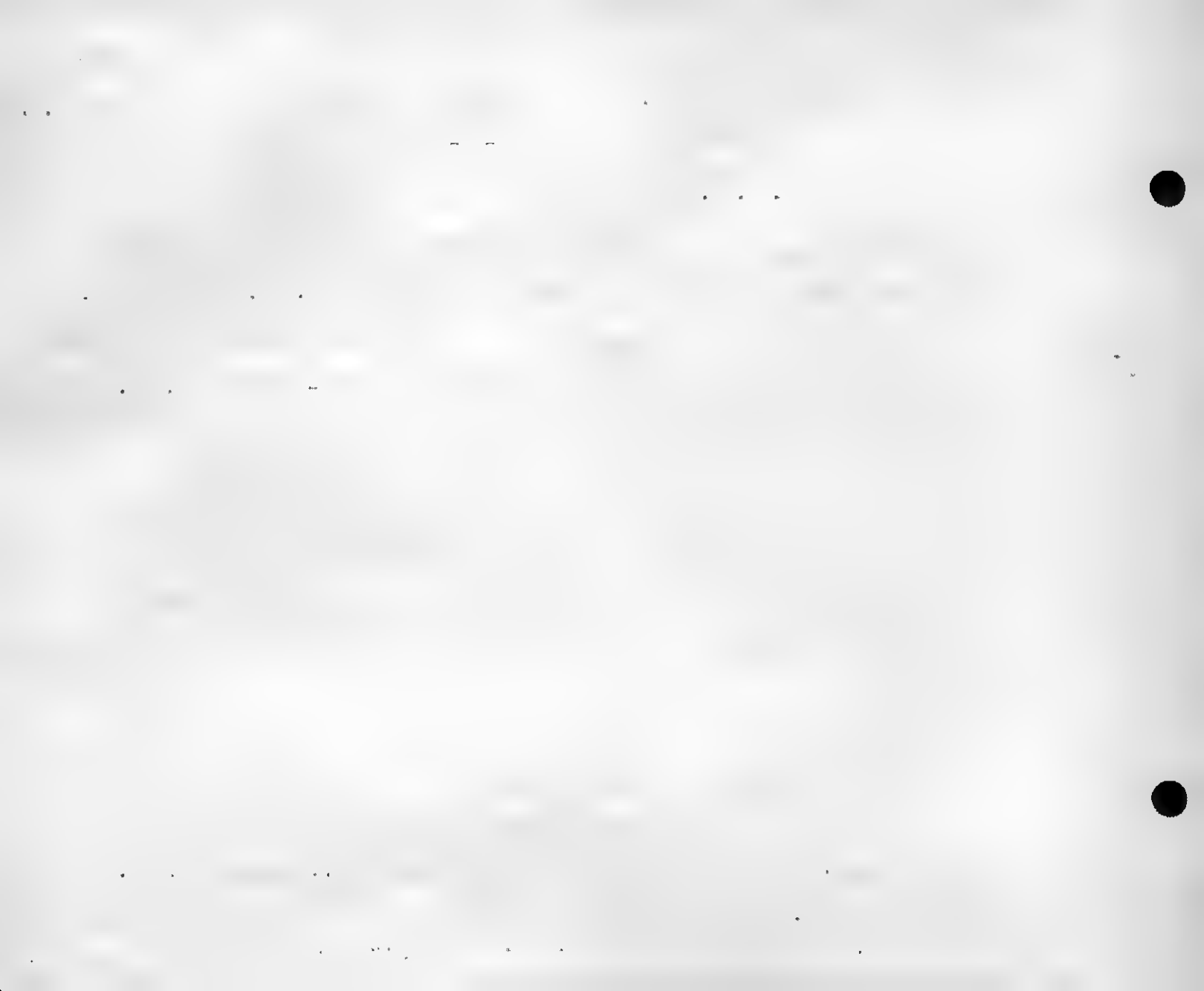
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH Month Day Year			2b HOUR		
JOSEPH HENRY GOEBEL						JAN. 10, 1969			1:00p M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS M.N.		2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR
MALE	WHITE	AUG. 20, 1912	56 YRS.					Jan. 10, 1969			2:00p M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
MARYLAND		USA				ALLEGANY Md					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
MT. SAVAGE			MT. SAVAGE			EMPLOYEE GLEN SAVAGE DAIRY FARM					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
MARYLAND			ALLEGANY		MT. SAVAGE				MT. SAVAGE, MARYLAND		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
WILLIAM GOEBEL			PEARL SHAW								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS						
NO					MRS LUCY E. GOEBEL MT. SAVAGE, MARYLAND						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pulmonary congestion and edema</u> DUE TO, OR AS A CONSEQUENCE OF <u>Cerebral edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chronic brain injury</u> (c) <u>Chronic brain injury</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24-48 hours About 3yrs., 7mos.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				21b TIME OF INJURY Month, Day, Year Evening May 29, 1965		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Pulled to ground by a calf and striking his head.					
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Farm		21f LOCATION Street or R.F.D. No Mt. Savage		City or Town Allegany		County Md.		State	
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D., FACP.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				January 10, 1969			
				ADDRESS (Street, city, town, or county)				CUMBERLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
BURIAL		JAN. 14, 1969		LAUREL HILL CEMETERY		MOSCOW MILLS ALLEGANY MD.					
24. FUNERAL DIRECTOR				25. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.				JAN 16 1969				<u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)		First WILLIAM		Middle H.		Last GREEN		2a. DATE OF DEATH Month 1 Day 19 Year 69	
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 9-23-1890		6. AGE (in years last birthday) 78 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during past of working life, even if retired) laborer		12b. KIND OF BUSINESS OR INDUSTRY Foundry			
13a. US. A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT. #4, OLDTOWN ROAD.	
14. FATHER'S NAME First GEORGE		Middle GREEN		Last MARGARET		15. MOTHER'S MAIDEN NAME First MARGARET		Middle CLAUSER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT Address MEMORIAL HOSPITAL- CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
PART 1. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) <i>Heart failure</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery disease</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Myocardial infarction</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>July 16, 1969</i> to <i>July 17, 1969</i> , that (I) (we) last saw the deceased alive on <i>July 17, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Dr. Hlane Schindler</i>		22c. DATE SIGNED <i>1/21/69</i>		22d. PHYSICIAN'S NAME (Type) DR. HLANE SCHINDLER					
22e. ADDRESS 43 GREENE ST., CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 22, 1969		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE JAN 21 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month		Day	Year	9:45 A.M.
3 SEX Female		4 RACE white		5. DATE OF BIRTH 5-17-1911		6. AGE (in years last birthday)		7. UNDER 1 YEAR MONTHS	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			
10 CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived if institution- Residence before admission) STATE MARYLAND		13b CITY OR TOWN CUMBERLAND		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET AND NUMBER 411 N. MECHANIC ST.,			
14 FATHER'S NAME First VIRGIL		Middle		Last CRAWFORD		15 MOTHER'S MAIDEN NAME First HAZEL		Middle KELLER	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b SOCIAL SECURITY NO NONE		17 INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia with shock & 5 days DUE TO, OR AS A CONSEQUENCE OF (b) kidney failure secondary DUE TO, OR AS A CONSEQUENCE OF (c) infected chemical burn right lower leg PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 1-13-1969, to 1-14-1969, that (I) (we) lost the deceased alive on 1-13-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Earl R. Paul				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) EARL R. PAUL				22e. ADDRESS 414 N. MECHANIC ST.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE JAN. 17, 1969		23c. NAME OF CEMETERY OR CREMATORY DAVIS MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.			
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.		25a. RECEIVED BY REG. SEAL JAN 21 1969		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First LESLIE			Middle M.			Last GROVE			2a. DATE OF DEATH Month 01 Day 04 Year 69			2b. HOUR 3:35 M		
3 SEX MALE			4. RACE WHITE			5 DATE OF BIRTH 09-09-95			6 AGE (In years last birthday) 73 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH ALLEGANY COUNTY, Md.								
10. CITY OR TOWN OF DEATH CUMBERLAND			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER			12b. OF BUSINESS OR INDUSTRY PAPER MILL								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN WESTERNPORT			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 420 WALNUT STREET					
14 FATHER'S NAME First JAMES			Middle GROVE			Last (FAZENBAKER) HARRIETT			15 MOTHER'S MAIDEN NAME First GROVE			Middle GROVE			Last GROVE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES			16b. SOCIAL SECURITY NO 217-05-0432			17 INFORMANT SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,			Address MD. 21502								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ADENOCARCINOMA OF PROSTATE WITH METASTASES 105 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) TERMINAL PNEUMONIA																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f. LOCATION Street or RFD No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 12 - 26 , 19 68 , to 1 - 4 , 19 69 , that (I) (we) last saw the deceased alive on 1 - 3 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Ralph W. Ballin			DEGREE MD.			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 1 - 4 - 69								
22d. PHYSICIAN'S NAME (Type) RALPH W. BALLIN, M.D.			22e. ADDRESS 62 GREENE ST CUMBERLAND, MD. 21502														
23a. BURIAL, CREMATION, REMOVAL, or other disposition BURIAL			23b. DATE 1/7/69			23c. NAME OF CEMETERY OR CREMATORY Philos			23d. LOCATION (City or Town) (County) (State) Westernport (County) MD								
24. FUNERAL DIRECTOR BOAL'S FUNERAL HOME, 111 CHURCH ST., WESTERNPORT			ADDRESS MD. 21562			25a. REC'D BY REGISTRAR JAN 10 1969			25b. REGISTRAR'S SIGNATURE James J. Judge								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First HAROLD		Middle M.		Last HAISLIP		2a. DATE OF DEATH Month 1 Day 27 Year 1969		2b. HOUR 6:45A	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH NOV 22, 1903		6 AGE (In years last birthday) 65 YRS		7 UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED BALTIMORE AND OHIO EMPLOYEE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) STATE MO.		13b. CITY		13c. CITY OR TOWN ALLEGANY CUMBERLAND		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 906 BRENTWOOD ST.			
14. FATHER'S NAME First GEORGE Middle Last HAISLIP		15. MOTHER'S MAIDEN NAME First ADA Middle Last MARTIN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOC AL SECURITY NO 705-05-5323		17. INFORMANT Address MRS ADA LEE HAISLIP 906 BRENTWOOD STREET							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Int. by Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Me informant</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State <u>Harold Haislip Alley, Md</u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>12/27/69</u> to <u>1/29/70</u> , that (I) (we) lost saw the deceased alive on <u>12/27/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dr. Williams</u>		22c. DATE SIGNED <u>1/29/70</u>				22d. PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS		22e. ADDRESS 122 SOUTH CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE JAN 30 1969		23c. NAME OF CEMETERY OR CREMATORY DAVIS MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) RFD# 4 CUMBERLAND ALLEGANY MD		25a. REC'D BY REGISTRAR JAN 30 1969			
24. FUNERAL DIRECTOR SILCOX-MERRITT		ADDRESS 404 DECATUR ST CUMBERLAND MD.				25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>					



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

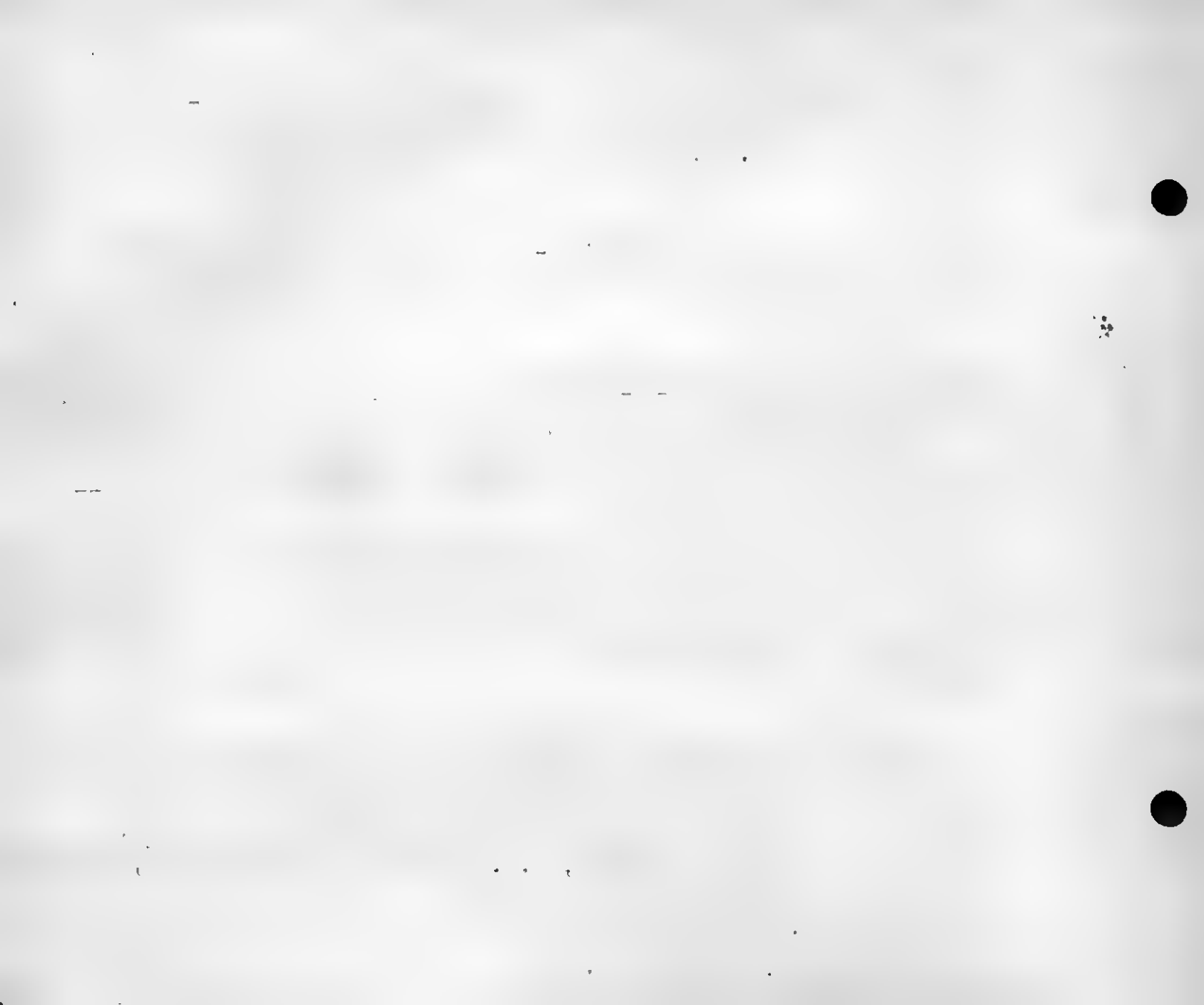
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1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR			
Walter James Hardesty						1-24-69			12:35p			M			
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. HOUR				
Male	White	Mar. 29, 1902	66 YRS					January 24, 1969			12:35p M				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.			
Maryland			U S A						Allegany						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF INDUSTRY						
Cumberland			Memorial Hospital-DOA			Retired Laborer			Allegany Electronics						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER			
Maryland			Allegany			Cumberland			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Route 1, Box 541 Valley Rd.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
First Middle Last			First Middle Last												
Hammill			Lee			Bertie			Hardesty						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			705-09-5317			Rosie M Golden, Rte 1, Bx 541, Cumberland, Md			Bowmans Addition						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) CORONARY OCCLUSION															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b) CORONARY SCLEROSIS															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)							
				19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				BENEDICT SKITARELIC, M.D.				22b. DATE SIGNED							
EXAMINER'S NAME (Type)								January 24, 1969							
								ADDRESS (Street, city, town, or county)							
								CUMBERLAND, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				Jan. 27, 1969				Sunset Memorial Park				Near Cumberland Alleg Md			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
John J. Hafer, Jr.				230 Balto Ave. Cumberland Md.				JAN 27 1969				Charles J. J...			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0003.										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00035																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
MAE FLORA F. HEADLEY										JANUARY 23 1969										3:48A																																							
3 SEX FEMALE										4 RACE WHITE										5. DATE OF BIRTH 1/19/1906										6 AGE (In years last birthday) 63 YRS										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HOURS HOURS MIN									
7a BIRTHPLACE (State or foreign country) MARYLAND										7b CITIZEN OF WHAT COUNTRY? USA										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH ALLEGANY										Md																			
10. CITY OR TOWN OF DEATH CUMBERLAND										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL										2c USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife										12b KIND OF BUSINESS OR INDUSTRY Own Home																													
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.										13b COUNTY ALLEGANY										13c CITY OR TOWN CUMBERLAND										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e STREET AND NUMBER 32 ROBERTS ST.																			
14 FATHER'S NAME First Middle Last BURTON C. APPOLD										15 MOTHER'S MAIDEN NAME First Middle Last MEADY F. WAGNER										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)										16b SOCIAL SECURITY NO										17 INFORMANT ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Left Ventricular Failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6hrs.																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) <u>Chronic Heart Failure</u>										8yrs.																																							
										(c) <u>Multi valvular disease; Myocardial Fibrosis</u>										Over 12 yrs.																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										Cholelithiasis, Liver Dysfunction																																																	
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED										20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)										21f LOCATION Street or R.F.D. No. City or Town County State																																							
22a I certify that (I) (this hospital) attended the deceased from 1956, to 1/23/1969, that (I) (we) last saw the deceased alive on Jan. 22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b SIGNATURE <u>[Signature]</u>										22c DATE SIGNED 1-24-69																																							
22d PHYSICIAN'S NAME (Type) DR. S. M. JACOBSON										22e ADDRESS 50 PERSHING ST., CUMBERLAND, MD.																																																	
23a BURIAL CREMATION REMOVAL (Specify) Burial										23b DATE Jan. 26, 1969										23c NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park										23d LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.																													
24 FUNERAL DIRECTOR SCARPELLI FUNERAL HOME, CUMBERLAND, MD.										25a REC'D BY REG STRAR										25b REGISTRAR'S SIGNATURE																																							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

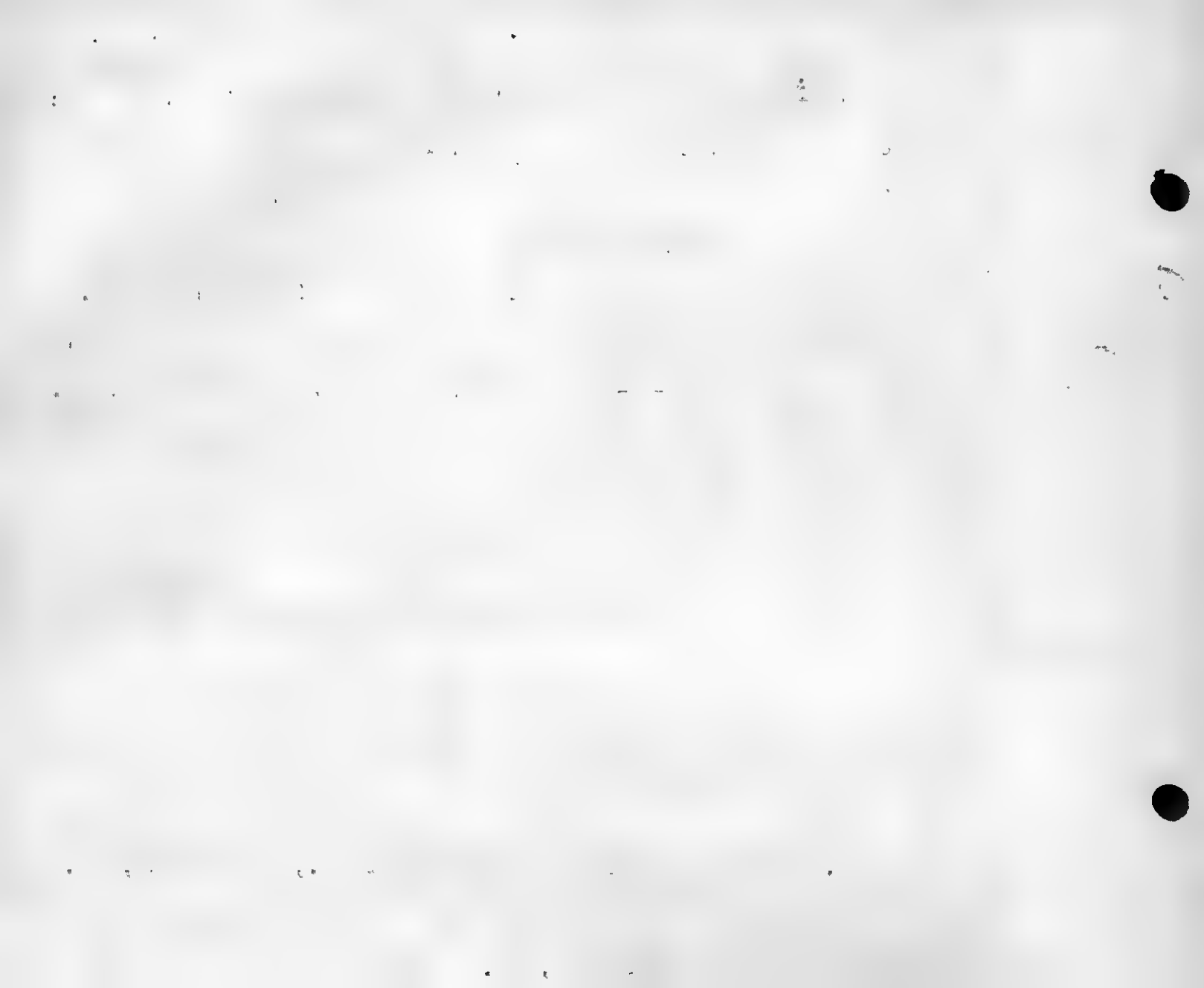
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) CRAWFORD			First Middle Last C. HENDRICKSON			2a. DATE OF DEATH JANUARY 10, 1969			2b. HOUR 11:20 PM		
3 SEX MALE			4 RACE WHITE			5. DATE OF BIRTH 2-6-1897			6 AGE (In years last birthday) 71 YRS.		
7a BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and no.) MEMORIAL HOSPITAL			12a. U.S.A. OCCUPATION (Kind of work done during life, even if retired) RETIRED Maintenance Man			12b. KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b COUNTY ALLEGANY			13c CITY OR TOWN LAVALLE			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME First Middle Last WILLIAM HENDRICKSON			15 MOTHER'S M.A.DEN NAME First Middle Last ELLEN SMITH								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) YES			16b SOCIAL SECURITY NO WW 1 214-05-6365			17 INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Crown Artery Disease</i>											
DUE TO, OR AS A CONSEQUENCE OF <i>Crown Artery Disease</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. 19 Month Day Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f LOCATION Street or R.F.D. No. Cumberland, Allegany			City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 1/10/69 to 1/10/69 , that (I) last saw the deceased alive on 1/10/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>R. J. Williams</i>			DEGREE PHYS			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED 1/12/69		
22d PHYSICIAN'S NAME (Type) R. J. WILLIAMS			22e ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.								
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE Jan. 1, 1969			23c NAME OF CEMETERY OR CREMATORY Rest Lawn Mem. Garden			23d LOCATION (City or Town) (County) (State) Cumberland Allegany Md.		
24 FUNERAL DIRECTOR William G. Kight			ADDRESS Cumberland, Md			25a REGISTERED JAN 18 1969			25b REGISTERED SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, retrieve carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRISTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)		First WILHELMINA		Middle		Last HENDRICKSON		2a. DATE OF DEATH JANUARY Month 23 Day 1969		2b. HOUR 2:00A
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 6/21/23		6 AGE (In years last birthday) 45 YRS		15 UNDER 1 YEAR MONTHS _____ DAYS _____		16 UNDER 24 HRS HOURS _____ MIN _____
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		Md		
10 CITY OR TOWN OF DEATH CUMBERLAND		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housekeeper		12b KIND OF BUSINESS OR INDUSTRY At Home				
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c CITY OR TOWN CUMBERLAND		13d INSIDE CITY, TOWN, VILLAGE, OR HAMLET <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		3e STREET AND NUMBER 625 SCHRIVER AVE.		
14. FATHER'S NAME First ROBERT		Middle SIMONS		Last HADDIE		15 MOTHER'S MAIDEN NAME First LANDIS		Middle LANDIS		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16b SOCIAL SECURITY NO. 219-14-6806		17 INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral aneurysm</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>1st stroke</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12/26/27</i>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ P.M. _____ Month _____ Day _____ Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No _____		City or Town _____		County _____ State _____		
22a. I certify that (I) (this hospital) attended the deceased from <i>January 1966</i> , to <i>January 23, 1969</i> , that (I) (we) last saw the deceased alive on <i>January 22, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Blane Schindler</i>		DEGREE DR. BLANE SCHINDLER		ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/24/69</i>				
22d. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER		22e. ADDRESS 43 GREENE ST., CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/25/69		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) _____ (County) _____ (State) _____		Cumberland Allegany Maryland		
24. FUNERAL DIRECTOR SILCOX FUNERAL HOME CUMBERLAND, MD.		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 27 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

30038

30038

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
James Douglas Heron						Month	Day	Year	8 A.M.		
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (in years last birthday)		F UNDER 1 YEAR		F UNDER 24 HRS	
Male	White		May 23, 1888			80 YRS.		MONTHS	DAYS	HOURS	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
West Va		U.S.A.				Allegany Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			630 Frederick Street			Retired - C & A Gas Company			Employee		
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Allegany			Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		630 Frederick Street	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
John D Heron						Carrie V Simmons					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS		
No			314-25-8185A			Martha Lee Heron			630 Frederick Street Cumberland, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cerebral vascular accident last of Dec '63</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21c. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>12-31-1963</u> to <u>1-21-1964</u> , that (I) (we) lost saw the deceased alive on <u>1-17-1964</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Wm J. Williams</u> DEGREE ATTENDING <input checked="" type="checkbox"/> MED <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS DIRECTOR PHYS								22c. DATE SIGNED <u>1-22-64</u>			
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County) (State)		
Burial		1/23/69		Rose Hill Cemetery			Cumberland Allegany Maryland				
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REG STAR		25b. REG STAR'S SIGNATURE	
Silcox-Merritt Funeral Service				Cumberland, Md				DATE JAN 29 1969		<u>Charles Judge</u>	



CERTIFICATE OF DEATH

00039

00039

1 DECEASED NAME (Type or print) BEULAH			First Middle Last			2a. DATE OF DEATH JANUARY Month 14 Day 69 Year			2b. HOUR 6:20A		
3 SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 8-1-25			6 AGE (In years last birthday) 43 YRS.		
7a BIRTHPLACE (State or foreign country) MARYLAND			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Gas Sta Operator with Husband			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.			13b. COUNTY ALLEGANY			13c. CITY OR TOWN OLDTOWN			3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME HARRY			First Middle Last			15 MOTHER'S MAIDEN NAME HAZEL			First Middle Last SNYDER		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b SOCIAL SECURITY NO.			17 INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD.			Address		
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocarditis</u>											
4/12/69 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Intermittent pneumonia</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus</u>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from <u>1-10-</u> , 19 <u>69</u> , to <u>1-14</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1-14</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Charles P. Dross</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <u>1-14-69</u>		
22d. PHYSICIAN'S NAME (Type) DR. V. DROSS						22e. ADDRESS 1909 FREDERICK ST. CUMBERLAND, MD.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE Jan. 16, 1969			23c NAME OF CEMETERY OR CREMATORY Sunset Memorial Park			23d LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md.		
24 FUNERAL DIRECTOR John J. Hafer, Jr.			ADDRESS Balto Ave Cumberland			25a. REC'D BY REGISTRAR JAN 17 1969			25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1 DECEASED-NAME (Type or print)			First HERLEN		Middle NEWTON		Last HOLLER		2a. DATE OF DEATH Month 01 Day 31 Year 69		2b HOUR 1:20 M			
3 SEX MALE		4 RACE WHITE			5 DATE OF BIRTH 03-08-04			6 AGE (In years last birthday) 64 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		8 UNDER 24 HRS. HOURS MIN		
7a BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY COUNTY, Md						
10 CITY OR TOWN OF DEATH CUMBERLAND			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) SACRED HEART HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CEMENT MASON			12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived if institution admission) STATE PENNSYLVANIA			13b CITY OR TOWN BOYNTON			13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER						
14. FATHER'S NAME First NEWTON			Middle HOLLER		Last HOLLER		15 MOTHER'S MAIDEN NAME First (STEELE)			Middle MARY			Last HOLLER	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b SOCIAL SECURITY NO 206-03-2106			17 INFORMANT SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,			Address MD. 21502					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) Complete Left Bundle Branch Block DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac Decompensation										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate ? 3 wks. ?				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary Embolus; Antero Septal Infarction Previous to 12/23														
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No		City or Town		County		State			
22a I certify that (I) (this hospital) attended the deceased from 1/24/ , 19 69 , to 1/31/ , 19 69 , that (I) (we) last saw the deceased alive on 1/30/ , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE <i>S.M. Jacobson</i>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 1-31-69						
22d PHYSICIAN'S NAME (Type) S.M. JACOBSON, M.D.						22e ADDRESS 50 PERSHING ST., CUMB., MD. 21502								
23a BURIAL CREMATION REMOVAL (Specify) BURIAL		23b DATE 2-3-69		23c NAME OF CEMETERY OR CREMATION SALISBURY I.O.O.F.			23d LOCATION (City or Town) (County) (State) SALISBURY - SOMERSET PA.							
24 FUNERAL DIRECTOR THOMAS FUNERAL HOME, SALISBURY, PENNSYLVANIA						ADDRESS		25a REC'D BY REGISTRAR FEB 5 1969		25b REGISTRAR'S SIGNATURE <i>Thomas Judge</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
ANNA May M.			HOWDYSHELL			01 23 69		12:50	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
FEMALE		WHITE		05-09-88		80 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
PENNSYLVANIA		U.S.A.				ALLEGANY COUNTY,			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		SACRED HEART HOSPITAL		Housewife		Own Home			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM 1st? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND				121 OAK STREET	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
FRANK CHAMBERLAIN			Harriet Chadwick						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO			800 00 6064		MD. 21502 SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u>								3 WEEKS	
4124 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACVD</u>								3 YEARS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>LYMPHATIC LEUCEMIA</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>11 - 4</u> , 19 <u>58</u> , to <u>1 - 23</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1 - 22</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>R. W. Ballin, M.D.</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE SIGNED <u>1-23-69</u>				
22d. PHYSICIAN'S NAME (Type) <u>R. W. BALLIN, M.D.</u>					22e. ADDRESS <u>62 GREENE ST., CUMB., MD. 21502</u>				
23a. BURIAL, CREMATION, or other disposition (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan. 25, 1969		Hillcrest Burial Park		Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
SCARPELLI FUNERAL HOME, 108 VA. AVE., CUMB., MD.					DATE <u>JAN 27 1969</u>		<u>Alvinas Judge</u>		

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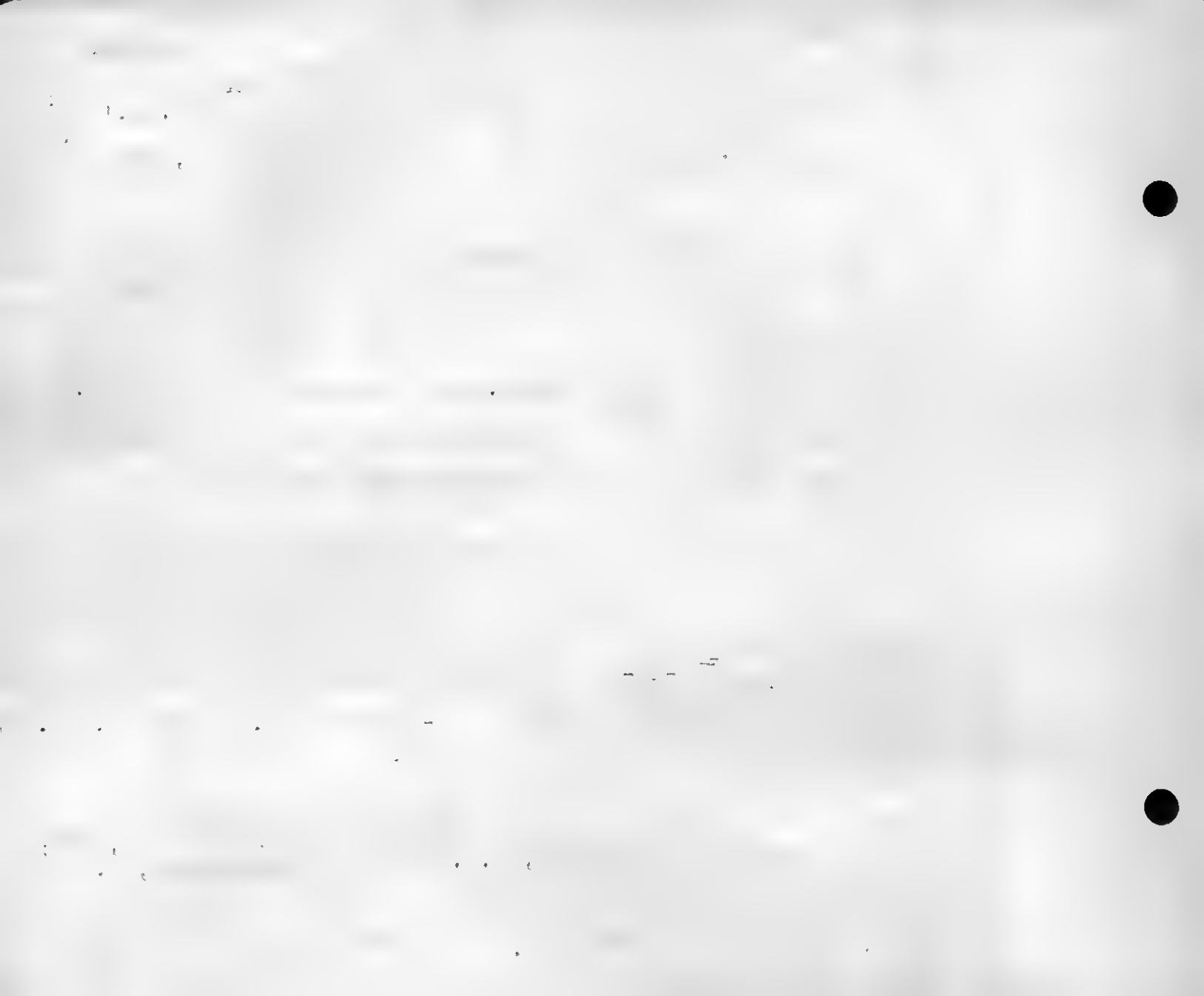
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

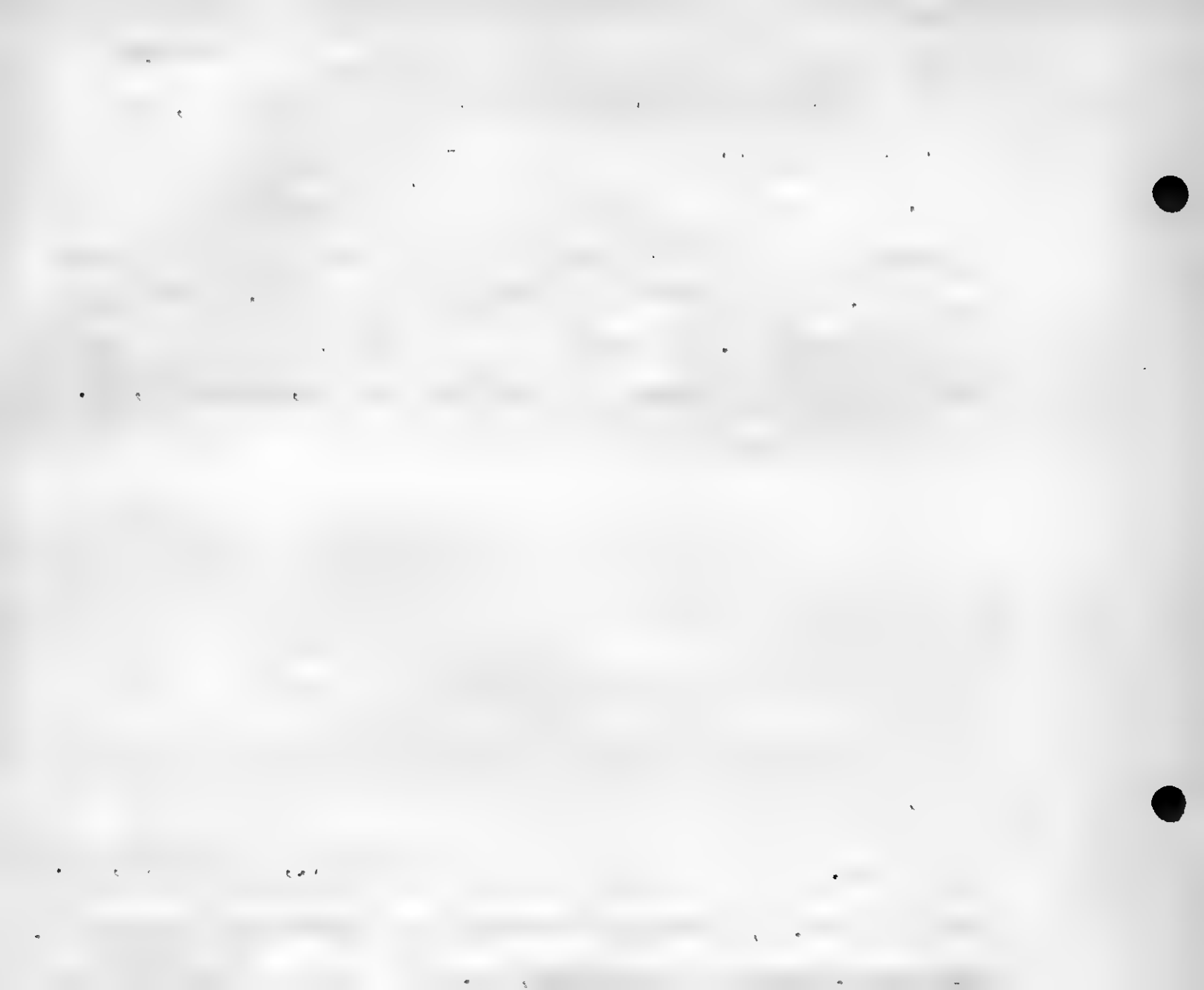
1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year				2b HOUR	
Doris		Ann		Huffman		Jan. 10, 1969				4:15 p.m.			
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year				
Female	White	Aug. 14, 1936		32 YRS					JANUARY 10, 1969				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH				Md			
Maryland		USA				Allegany							
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY			
Cumberland		MEMORIAL HOSPITAL-DOA				Nurses Aid				Hospital			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before adm'ssion) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER					
Md.		Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		413 Grand Ave.					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle	
Dailey Howdyshell								Marie Slater					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		ADDRESS		Mother					
no		(If yes give war or dates of service)		219-34-5913		Mrs. Marie Howdyshell, Cumberland, Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CRUSHED SKULL DUE TO, OR AS A CONSEQUENCE OF (b) (STRUCK BY FREIGHT TRAIN) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				21b TIME OF INJURY Month Day, Year HOUR MIN 3:45 P.M. 1-10-69				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Struck by Freight train on RR crossing					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) RR crossing				21f LOCATION Street or R.F.D. No City or Town County State Crossing-Avirett Ave. Cumberland, All. Md.					
22a. I certify that I took charge of the removals described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Benedict Skitarelio</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED					
EXAMINER'S NAME (Type)				Benedict Skitarelio, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				January 10, 1969	
				ADDRESS (Street, city, town, or county)				Cumberland, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)							
Burial		Jan. 13, 1969		Rio Cemetery		Rio, W. Va.							
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.								JAN 15 1969		<i>James F. Scarpelli</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00043		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		00043	
Item 1, Film 6409 2/19/69 cac					
1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year
BABY Diana		GIRL	Carol	HUGHES	JANUARY 7, 1969
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)
FEMALE	WHITE		1-7-1969		18 YRS
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH
MD.	USA				ALLEGANY
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
CUMBERLAND		MEMORIAL HOSPITAL		None	
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN	
MD.		ALLEGANY		CUMBERLAND	
14 FATHER'S NAME First Middle Last		15 MOTHER'S MAIDEN NAME First Middle Last		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
WILLIAM R. HUGHES		CAROLINA M. EASTON		5 MT. VERNON PLACE	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b SOCIAL SECURITY NO		17 INFORMANT Address	
No		None		MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 7760 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Anoxia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Meconium Aspiration</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Robert Brodell</u>		22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)	
				DR. ROBERT BRODELL	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Burial		Jan. 8, 1969		Sunset Memorial Park	
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR DATE	
William G. Kight		Cumberland, Md.		JAN 11 1969	
				25b REGISTRAR'S SIGNATURE <u>William G. Kight</u>	

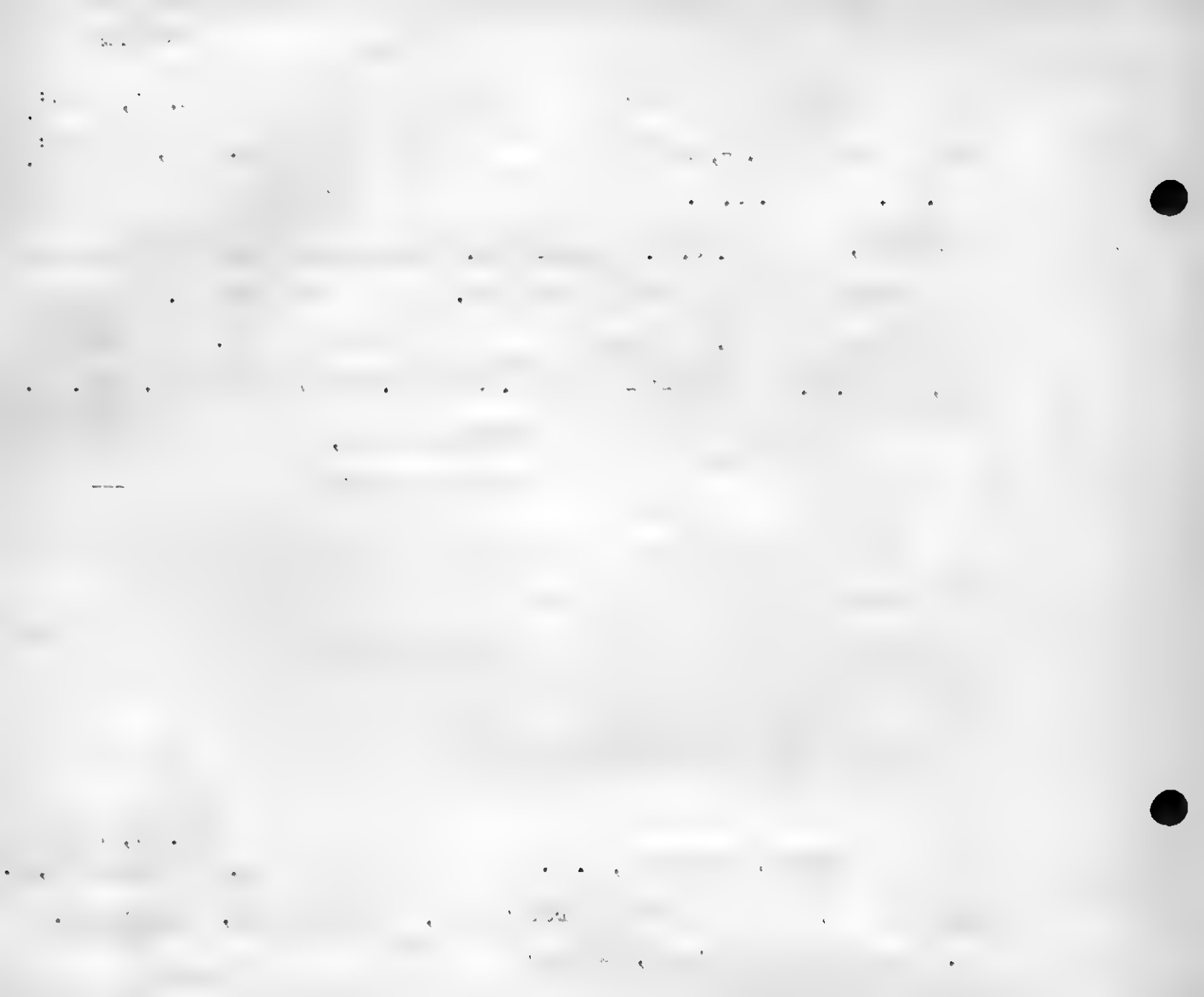


FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED NAME (Type or Print)			First William			Middle Mason			Last Judy			2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year Jan. 27, 1969			2b. HOUR 1:55 P.M.		
3 SEX Male		4 RACE White		5 DATE OF BIRTH Oct. 4, 1894		6 AGE (in years last birthday) 74 YRS		F UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year Jan. 27, 1969			2d. HOUR 1:55 P.M.		
7a. BIRTHPLACE (State or foreign country) W. Va.				7b. C.T.ZEN. OF WHAT COUNTRY? U. S. A.				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Allegany					
10. CITY OR TOWN OF DEATH Cumberland,				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D. O. A. Memorial Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Stationary Fireman				12b. KIND OF BUSINESS OR INDUSTRY Potomac Edison					
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before adm. ssion) STATE Maryland				13b. COUNTY Allegany				13c. CITY OR TOWN Cumberland,				13d. NO. DE C.T.Y. L.M. 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 736 Greene St.			
14. FATHER'S NAME First Middle Last George K. Judy						15. MOTHER'S MAIDEN NAME First Middle Last Mary A. Harman											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) Yes, W. W. #1						16b. SOCIAL SECURITY NO. 217-10-9584			17 INFORMANT ADDRESS Mrs. Violet M. Judy 736 Greene St. Cumb. Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4109 CORONARY OCCLUSION, DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. CORONARY SCLEROSIS (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Benedict Skitarelic				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED Jan. 27, 1969					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
								ADDRESS (Street, city, town, or county) Rt. # 9 Cumberland, Md.									
23a. BURIAL, CREMATION, REMOVA. (Specify) Burial				23b. DATE 1/30/69		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park,				23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.							
24 FUNERAL DIRECTOR H. Wayne George						ADDRESS Cumberland, Maryland						25a. RECEIVED BY REGISTRAR JAN 30 1969		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

0004.			00045				
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	2b. HOUR
KATHERINE NMI KERNS						1 Month 11 Day 69 Year	4:25 PM
3 SEX	4. RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
FEMALE	WHITE	8 26 07	61 YRS.				
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH				
MISSOURI	USA		ALLEGANY			Md.	
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY				
CUMBERLAND, MD.	SACRED HEART HOSPITAL	HOUSEWIFE					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
MARYLAND	ALLEGANY	CUMBERLAND		212 CECILIA STREET			
14 FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last
PHILLIP CAMPBELL				ELIZABETH (MOBLEY) CAMPBELL			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b SOCIAL SECURITY NO.	17 INFORMANT	Address				
NO	NONE	HOSPITAL RECORDS	300 SETON DRIVE CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of endometrium with</u> <u>1 x 2 x</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>abdominal metastasis cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>6 months</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
1967		cancer of endometrium		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>3-1</u> , 19 <u>67</u> , to <u>1-11</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>1-10</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c DATE SIGNED		
<u>L. Brings MD</u>					<u>1-12-69</u>		
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS					
DR. LEWIS BRINGS		57 GREENE STREET -CUMBERLAND, MARYLAND					
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)				
BURIAL	JAN. 14, 1969	SUNSET MEMORIAL PARK	CUMBERLAND, MD.				
24 FUNERAL DIRECTOR	ADDRESS		25a RECEIVED BY	25b REGISTERED			
KIGHT'S FUNERAL HOME	-309 DECATUR	-CUMBERLAND	MAN 10 1969				
		DATE					

1. The first part of the report
describes the general situation
of the country and the
state of the economy.
It also mentions the
political situation and
the state of the
army.

2. The second part of the report
describes the situation in the
provinces and the state of the
economy in each of them.
It also mentions the
political situation and
the state of the
army in each of them.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00040

00046

1. DECEASED NAME (Type or print)		First WILLIAM	Middle M.	Last KESNER	2a. DATE OF DEATH Month 25 , Day 1969 , Year 1969		P.M. 11:35	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 2-5-1922-2-5-22		6. AGE (in years last birthday) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Carman		12b. KIND OF BUSINESS OR INDUSTRY B & O R.R.		
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 523 FRANK'S LANE
14. FATHER'S NAME First CHARLES Middle KESNER Last KESNER		15. MOTHER'S M.A.D.E.N. NAME First MARY Middle L. Last RODEHEAVER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) yes (If yes give war or date - if service) War II-44		16b. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Left Lung with Metastases</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>One year</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>1-23-69</u> , 19 <u>69</u> , to <u>1-25</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1-25-69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE <u>Calvin Y. Hadidian</u>		DEGREE DR. CALVIN Y. HADIDIAN		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-28-69		
22d. PHYSICIAN'S NAME (Type) DR. CALVIN Y. HADIDIAN		22e. ADDRESS 203 GREENE ST., CUMBERLAND, MD.						
23a. BURIAL (CREMATION REMOVAL) (Specify) Burial		23b. DATE Jan. 29, 1969		23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REG. STRAR DATE FEB 4 1969		25b. REG. STRAR'S SIGNATURE <u>Charles Judge</u>		

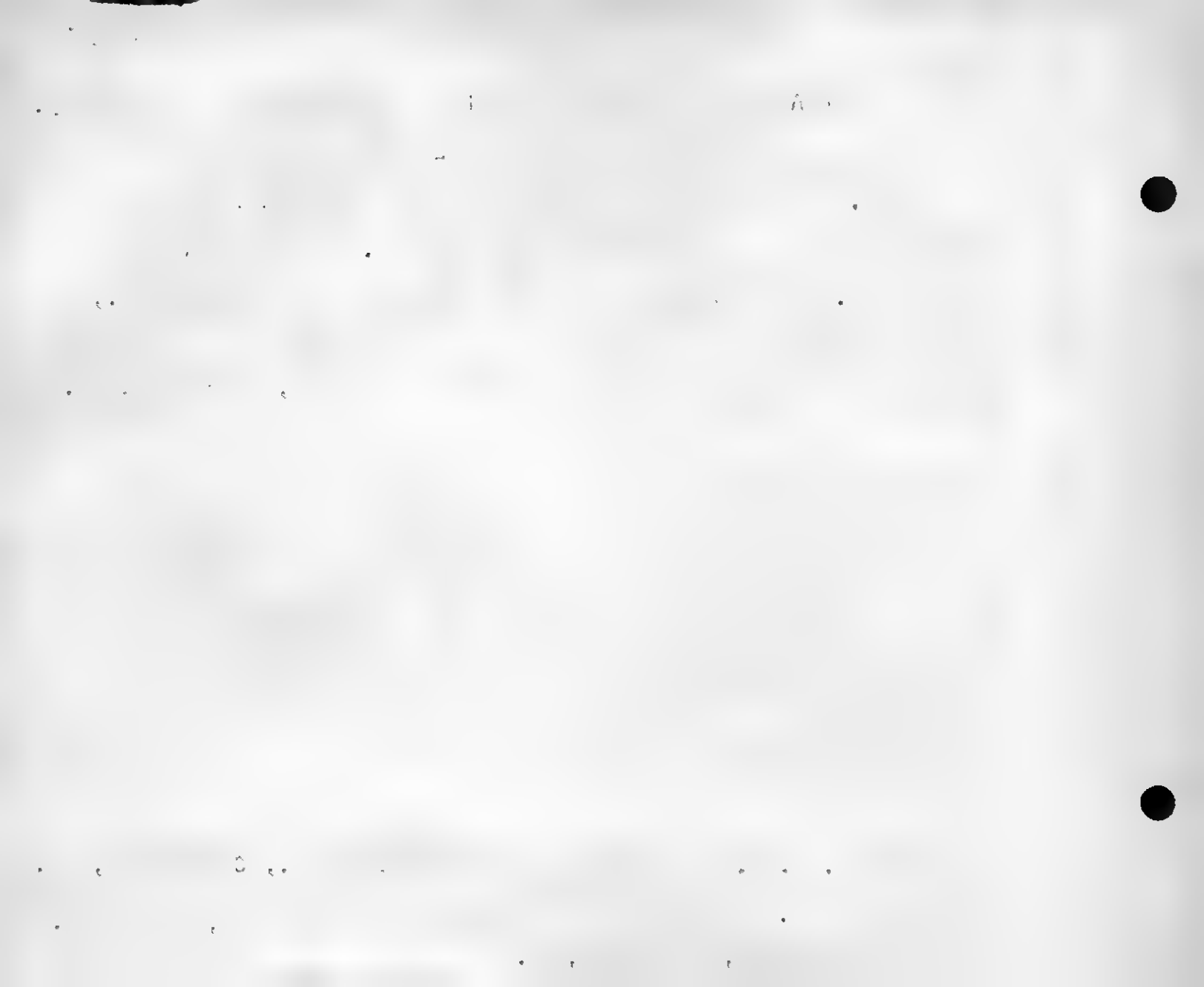


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Item 6 Film 408 1/13/69 kk										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print) CHARLES V KIFER					2a. DATE OF DEATH Month JANUARY Day 5 Year 1969			2b. HOUR 3:15		
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH 8-12-1899		6 AGE (In years last birthday) 69 YRS		IF UNDER 1 YEAR MONTHS 69 DAYS 69		
7a BIRTHPLACE (State or foreign country) PENNA.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY				
10. CITY OR TOWN OF DEATH CUMBERLAND			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of work life, unless otherwise stated) MD. WORKSHOP FOR BLIND		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.			13b COUNTY ALLEGANY		13c CITY OR TOWN CUMBERLAND		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 913 GRAND AVE.,	
14 FATHER'S NAME First JOHN Middle KIFER Last KIFER			15 MOTHER'S MAIDEN NAME First MARGARET Middle FAHEY Last FAHEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b SOCIAL SECURITY NO.		17 INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Subarachnoid Hemorrhage 4500 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street factory) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1/5 19 69 , to 1/5 19 69 , that (I) (we) last saw the deceased alive on 1/5 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Dr. S. G. Weisman					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/6/69			
22d. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN					22e ADDRESS 59 GREENE ST., CUMBERLAND, MD.					
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE Jan. 8, 1968		23c NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.				
24 FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.					25a REC'D BY REGISTRAR DAVID G 1969		25b REGISTRAR'S SIGNATURE Charles J. ...			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First CATHERN		Middle ANGELLA		Last KLINK		2a DATE OF DEATH Month <u>01</u> Day <u>08</u> Year <u>69</u>		
3 SEX FEMALE			4 RACE WHITE		5. DATE OF BIRTH <u>09-18-03</u>			6 AGE (In years lost birthday) <u>65</u> YRS		2b HOUR A 12:50 M	
7a BIRTHPLACE (State or foreign country) PENNSYLVANIA			7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH ALLEGANY COUNTY Md				
10 CITY OR TOWN OF DEATH CUMBERLAND			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased admission) STATE PENNSYLVANIA			13b CITY OR TOWN MEYERSDALE		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER RT. #4, BOX 238				
14. FATHER'S NAME First PATRICK			Middle LUDDEN		Last LUDDEN		15 MOTHER'S MAIDEN NAME First (BRODENICK) CATHERYNE				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b SOCIAL SECURITY NO 162-16-5638		17 INFORMANT SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,			Address MD. 21502			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> <u>244X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Myxedema and RHD</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pulmonary Emphysema</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>D. Matthew Karp</u>						22c. DATE SIGNED 1-8-69					
22d. PHYSICIAN'S NAME (Type) M. KAUFFMAN, M.D.						22e. ADDRESS 912 SETON DRIVE, CUMB., MD. 21502					
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE 1/11/69			23c. NAME OF CEMETERY OR CREMATORY SS PHILIP JAMES CEME			23d. LOCATION (City or Town) (County) (State) MEYERSDALE Som Co. PA		
24 FUNERAL DIRECTOR M. H. Zepson						25a. REC'D BY REGISTRAR JAN 15 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		
PRICE FUNERAL HOME, MEYERSDALE, PENNSYLVANIA											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) Sarah Mae Kriglein					2a. DATE OF DEATH @ 4:45 P.M. Month January Day 22 Year 1969		2b. HOUR P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3/14/1886		6. AGE (In years last birthday) 82 YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany County Md.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 306 Auburn Avenue	
14. FATHER'S NAME First Mathew Middle Schaffer Last Catherine					15. MOTHER'S MAIDEN NAME First Catherine Middle Heiland Last Heiland				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 220-10-9151		17. INFORMANT P.O. Box 599, Cumberland, Md. DI Allegany County Infirmary records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident 4567 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis (c) Pneumonia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks yes -
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Aug 15, 1968 to Jan 22, 1969 , that (I) (we) last saw the deceased alive on 1/21 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE George M. Simons, M.D.				DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1/22/69	
22b. PHYSICIAN'S NAME (Type) George M. Simons, M.D.				22e. ADDRESS Memorial Hospital, Cumberland, Md. 21502					
23a. BURIAL, CREMATION, RENOVATION (Specify)		23b. DATE Jan. 25, 1969		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR JAN 27 1969		25b. REGISTRAR'S SIGNATURE James F. Scarpelli			

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month		Day	Year	2b HOUR 2:00 M
NORENE			E.		LARKIN	01		18	69	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 11-02-91		6 AGE (In years lost day)		7 UNDER 1 YEAR MONTHS		8 UNDER 24 HRS HOURS
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH ALLEGANY COUNTY, Md				
10 CITY OR TOWN OF DEATH CUMBERLAND			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b COUNTY ALLEGANY		13c CITY OR TOWN FROSTBURG	13d INS OF CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER RT#2, BOX 203, FROST., MD.		
14 FATHER'S NAME WILLIAM			First		Middle	15 MOTHER'S MAIDEN NAME (LOGSDON) EMMA		First		Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b SOCIAL SECURITY NO. 217-54-6820		17 INFORMANT SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD.		Address 21502			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LEFT VENTRICULAR FAILURE										3 WEEKS
4124 DUE TO, OR AS A CONSEQUENCE OF, ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE										5 YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
INFLUENZA										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCAT ON Street or R.F.D. No		City or Town		County	State
									(69)	
22a I certify that (I) (this hospital) attended the deceased from 12 DECEMBER 19 68, to 1 - 18, 19 68, that (I) (we) last saw the deceased alive on 1 - 18, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b SIGNATURE R.W. Ballin M.D.					DEGREE ATTENDING PHYS		MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 1-19-69	
22d. PHYSICIAN'S NAME (Type) R.W. BALLIN, M.D.					22e. ADDRESS 62 GREENE ST., CUMBERLAND, MD. 21502					
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 1-21-69		23c NAME OF CEMETERY OR CREMATORY ST. PATRICK'S CEMETERY		23d LOCAT ON (City or Town)		(County)	(State)	
24 FUNERAL DIRECTOR DURST FUNERAL HOME, 57 FROST AVE., 68 FROST.					25a ADDRESS MD. 21532		25b JAN 23 1969		25c REGISTRAR'S SIGNATURE	

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print) First Middle Last JOHN FRANCIS LEEDY			2a. DATE OF DEATH Month Day Year 01 04 69			2b. HOUR P 11:55M				
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 06-24-96		6 AGE (in years last birthday) 72 YRS.		7 UNDER 1 YEAR MONTHS DAYS 8 UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH ALLEGANY COUNTY, Md				
10 CITY OR TOWN OF DEATH CUMBERLAND			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, or usual retired) Rec. Traction Master		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 216 S. LEE STREET	
14. FATHER'S NAME First Middle Last JAMES LEEDY			15. MOTHER'S MAIDEN NAME First Middle Last (OSBORNE) ELIZABETH LEEDY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO 714-05-6814		17 INFORMANT Address SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced Carcinoma of Liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>& Atherosclerosis</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u> <u>6 mos.</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 11/7/69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1968</u> , to <u>11/4 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>J. A. Pagan</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE SIGNED <u>11/7/69</u>					
22d. PHYSICIAN'S NAME (Type) <u>J.A. PAGAN, M.D.</u>					22e. ADDRESS <u>1068 NATIONAL HWY., LA VALE, MD. 21502</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>11/7/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul's Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Allegany, Md.</u>				
24. FUNERAL DIRECTOR <u>H. Wayne George</u> ADDRESS <u>GEORGE FUNERAL HOME, 202 GREENE ST., CUMB., MD.</u>					25a. REC'D BY REGISTRAR <u>MAN 9</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or print)			First JOSEPH		Middle G.		Last LEWIS		2a. DATE OF DEATH Month <u>JANUARY</u> Day <u>15th</u> Year <u>1969</u>		2b. HOUR <u>4:57</u> PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH OCT. 1ST, 1899			6. AGE (In years last birthday) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md							
10. CITY OR TOWN OF DEATH FROSTBURG,			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINER'S HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MAINTENANCE			12b. KIND OF BUSINESS OR INDUSTRY W. MD. R. R.				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG,		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 24 STOYER STREET,				
14. FATHER'S NAME First THEOPHILUS			Middle LEWIS		Last IDA		15. MOTHER'S MAIDEN NAME First IDA			Middle GEARY		Last GEARY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown			16b. SOCIAL SECURITY NO 217-03-1605		17. INFORMANT MRS. ELIZABETH LEWIS,			Address FROSTBURG, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY													
IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u>													
4123 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b) <u>Myocardial ischemia</u>												12 yrs.	
DUE TO, OR AS A CONSEQUENCE OF													
(c) <u>Coronary arteriosclerosis</u>												12 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Emphysema, moderately severe.</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from <u>Jan. 11, 1969</u> , to <u>Jan 15, 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan 15, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death.													
22b. SIGNATURE <u>Alvin J. Walters</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <u>1/17/69</u>				
22d. PHYSICIAN'S NAME (Type) ALVIN J. WALTERS,						22e. ADDRESS 48 BROADWAY, FROSTBURG, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 1-18-69		23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK			23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.					
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532						25a. REC'D BY REGISTRAR DATE JAN 20 1969			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 5 may be retained for your files.

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00053

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00053

1. DECEASED NAME (Type or Print) Ronald Young Lohr, Sr.			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Jan. Day 31 Year 1969			2b. HOUR 4:40p M		
3 SEX Male	4 RACE White	5. DATE OF BIRTH 1/1/1912	6. AGE (In years last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS 	IF UNDER 24 HRS HOURS MIN 	2c. DATE PRONOUNCED DEAD Month January Day 31 Year 1969 19 4:40p M		
7a. BIRTHPLACE (State or foreign country) Spokane Wash.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Allegany Md		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Memorial Hospital--DOA		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Conductor		12b. KIND OF BUSINESS OR INDUSTRY B&O R.R.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Flintstone		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Flintstone Rt #2
14. FATHER'S NAME First Peter Middle Young Last Lohr			15. MOTHER'S MAIDEN NAME First Rose Middle Dawson Last 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Ronald Y. Lohr Sr.		ADDRESS Flintstone Rt #2		
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 410 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis, Left DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Sclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden " ---
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State 				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Benedict Skitarellic		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED January 31, 1969		
				ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
				ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/4/68		23c. NAME OF CEMETERY OR CREMATORY Davis Memo. Pk.		23d. LOCATION (City or Town) Cumberland (County) Allegany (State) MD		
24. FUNERAL DIRECTOR Louis Stein Inc.		ADDRESS Cumb. Md.		25. REC'D BY REGISTRAR FEB 3 1969		25b. REGISTRAR'S SIGNATURE 		

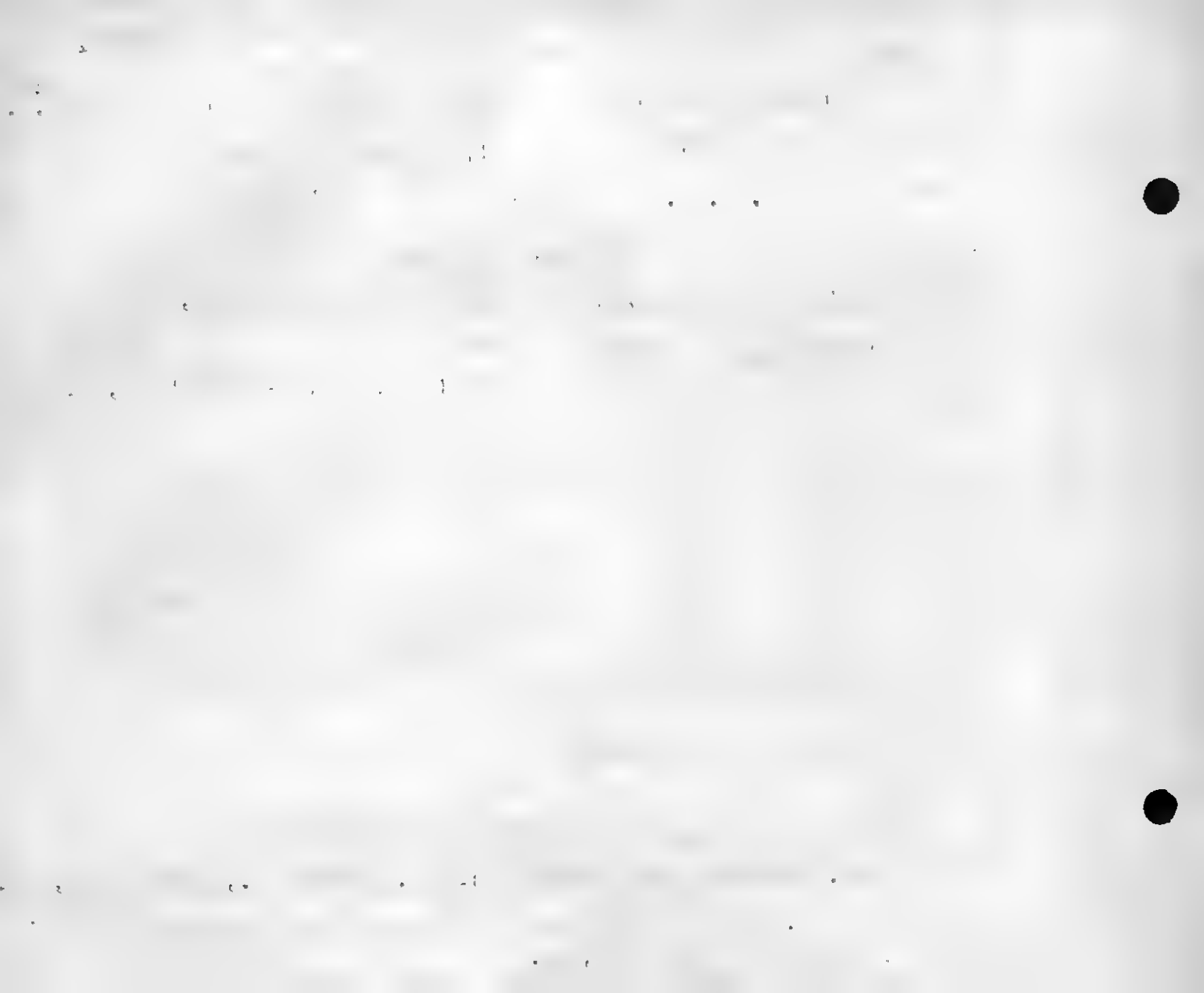


Page 4 may be retained by the hospital or attending physician.

69

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
00054 CERTIFICATE OF DEATH 00054												
1 DECEASED NAME (Type or print) MICHAEL HUMBIRD LONG						2a. DATE OF DEATH Month 1 Day 2 Year 69			2b. HOUR 9:00 A.M.			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 11-25-1888			6 AGE (in years last birthday) 80 YRS.		7 UNDER YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH ALLEGANY						
10 CITY OR TOWN OF DEATH CUMBERLAND		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer			12b KIND OF BUSINESS OR INDUSTRY Own Farm			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b COUNTY ALLEGANY		13c CITY OR TOWN CUMBERLAND		13d IN DC CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER ROUTE #4,				
14 FATHER'S NAME First Middle Last MICHAEL LONG				15 MOTHER'S MAIDEN NAME First Middle Last SALLIE STICKLEY								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral aneurysm 13. X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral aneurysm of posterior DUE TO, OR AS A CONSEQUENCE OF (c) 3 years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 1967 , to 2 Jan, 1969 , that (I) (we) lost saw the deceased alive on 1969 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE DR. FREDERICK MILTENBERGER						22c. DATE SIGNED 4 Jan 1969		22d. PHYSICIAN'S NAME (Type) DR. FREDERICK MILTENBERGER				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE Jan. 4, 1969		23c NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		23d LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.		23e. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR JAN 7 1969		25b. REGISTRAR'S SIGNATURE [Signature]				

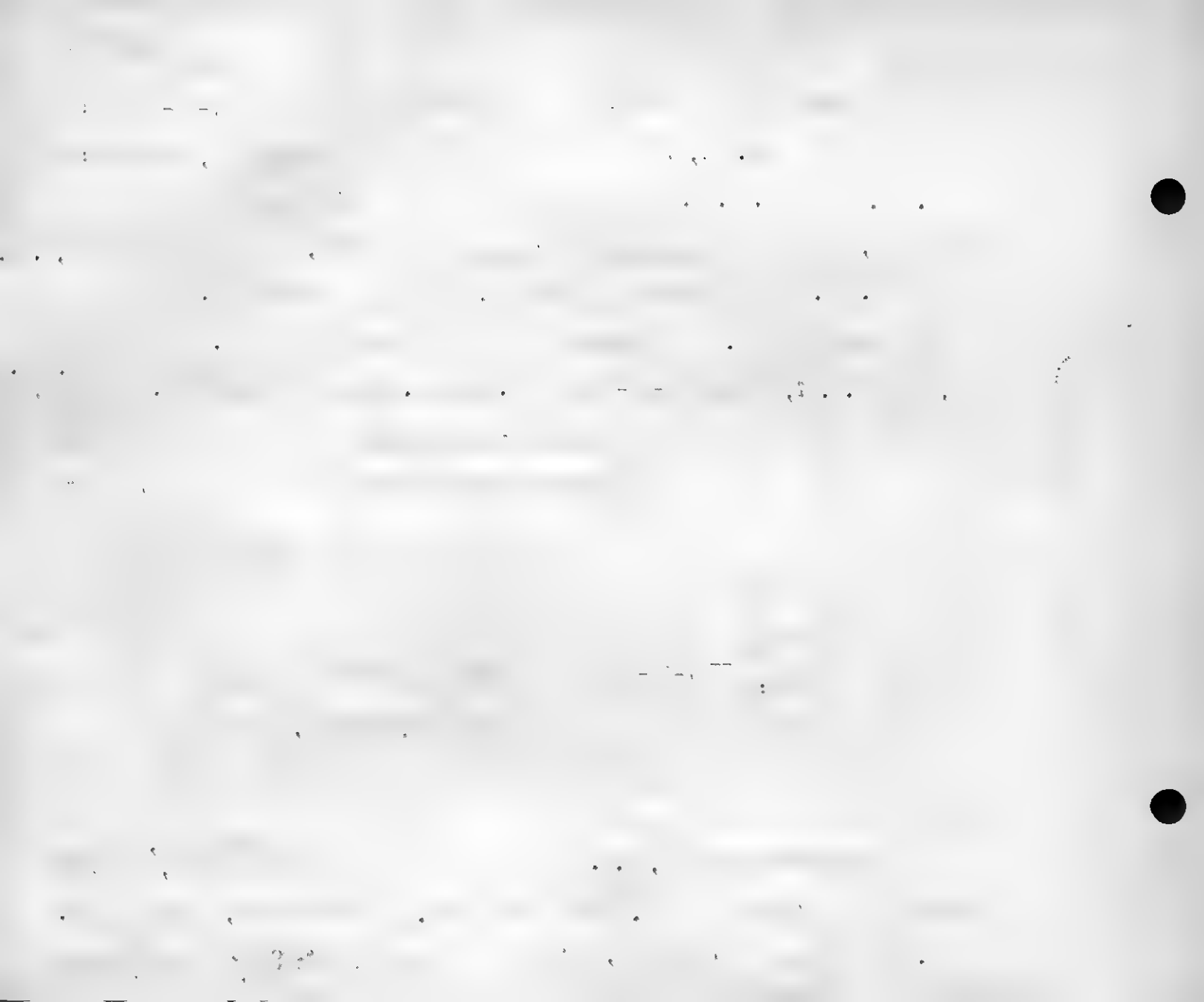


**FOR STATE
HEALTH DEPT.**

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00055		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										00055		
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR	
Joseph Michael Malamphy									XX Month Day Year 1-14-69		4:00 a M	
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR	
Male	White	Aug. 24, 1924		44 YRS					January 14, 1969		194:00 a M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
W. Va.		U. S. A.				Allegany						
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
Cumberland,			Sacred Heart Hospital			Laborer,			Town of Ridgeley, W. Va.			
13a U.S.A. RESIDENCE (Where deceased lived if institution residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
W. Va.			Mineral		Ridgeley,				Knobley Rd.			
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
John M. Malamphy			Anna M. Troll									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS					
Yes			W. W. #2, Korean 233-34-5494		Mrs. Anna M. Malamphy		Knobley Rd. Ridgeley, W. Va.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY THERMAL BURNS										10 Hours		
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last												
(b) (CONFLAGRATION OF DWELLING)										10 Hours		
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR:MIN. 6:00 P.M. 1-13-69			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Trapped in burning dwelling						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home			21f LOCATION Street or R.F.D. No City or Town County State RIDGELEY, MINERAL, WEST VIRGINIA						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						DEPUTY MEDICAL EXAMINER XX JANUARY 14, 1969						
						ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND						
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)						
Burial		1/17/69		SS. Peter & Paul Cem.		Cumberland, Allegany Md.						
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
H. Wayne George				Cumberland, Maryland				JAN 17 1969		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00056											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) ALFRED First BRISON Middle MASON Last						2a. DATE OF DEATH JANUARY 23, 1969 Year 1969 Month January Day 23			2b. HOUR 5:50 PM		
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 6-10-1875		6 AGE (In years last birthday) 93 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CIT ZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY					
10 CITY OR TOWN OF DEATH CUMBERLAND		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during life, or for 30 days before death, if retired) RETIRED - custodian		12b. KIND OF BUSINESS OR INDUSTRY Tire Industry					
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE MARYLAND		13b COUNTY ALLEGANY		13c CITY OR TOWN CUMBERLAND		13d. IN CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 20 WRIGHT'S AVE., GREEN			
14. FATHER'S NAME First BUCKNER Middle MASON Last MASON				15 MOTHER'S MAIDEN NAME First CLARA Middle WILBURN Last WILBURN							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)				16b SOCIAL SECURITY NO 220-10-8749		17 INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) carcinomatosis											
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma Prostate											
DUE TO, OR AS A CONSEQUENCE OF (c) 185 X											
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) A.S. Cardiovascular disease with gen. arteriosclerosis 10 years											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or RFD No City or Town County State							
22a I certify that (I) (this hospital) attended the deceased from 1955 , 19____, to____, 19____, that (I) (we) last saw the deceased alive on 23 Jan 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE W. A. Van Normer, M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) DR. W. A. VANORMER				22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/26/69		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.					
24 FUNERAL DIRECTOR H. Wayne George Cumberland, Md.				25a. REC'D BY REGISTRAR JAN 28 1969		25b. REGISTRAR'S SIGNATURE [Signature]					

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00057

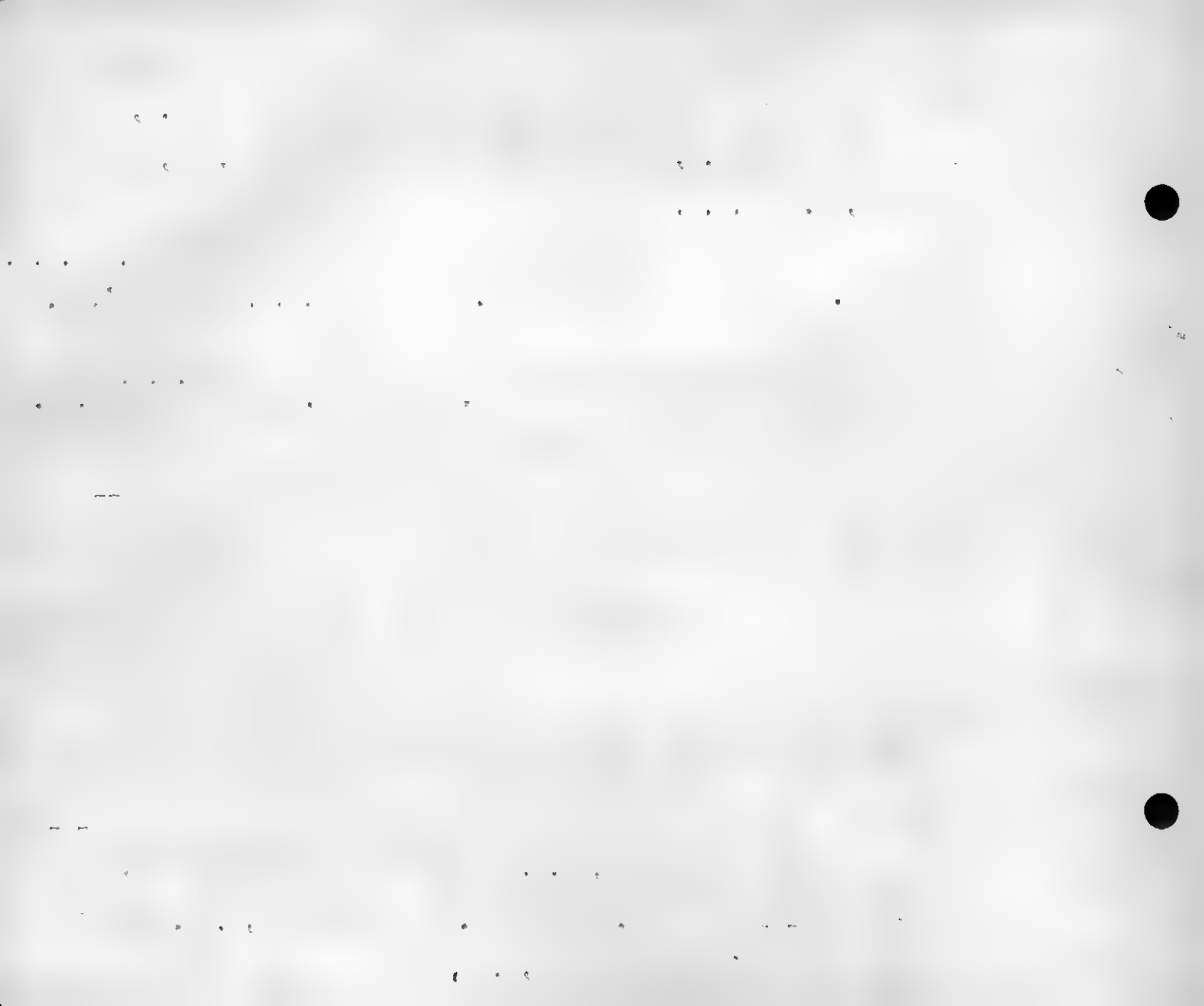
00057

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH Month Day Year			2b HOUR		
Francis Joseph McDade						Month Day Year			1969		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years and birthday)	7. IF UNDER 1 YEAR	8. IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR		
Male	White	July 9, 1904	64 YRS	5 MONTHS	24 DAYS	Month Day Year			1969		
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Frostburg, Md.			U.S.A.						Allegany		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
McCoole			Route 220			Retired Trackman			B. & O. R.R.		
13a. U.S.A. RESIDENCE (Where deceased lived, if not institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md.			Allegany			McCoole.			R.F.D. 3 Rawlings, Md.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		
Charles McDade			Ellen Begley			No			No		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Mrs. Margaret B. McDade			R.F.D. 3 Box, 13			(Wife)			SUDDEN		
19. IMMEDIATE CAUSE (a)			CORONARY OCCLUSION			DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			CORONARY SCLEROSIS			--		
(c)			DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED		
Benedict Skitarelic			M.D.						1-3-69		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)					
BENEDICT SKITARELIC, M.D.			XX			CUMBERLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			1-7-69			St. Thomas Cem.			Keyser, W. Va. Mineral		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Harold W. McKenzic			Keyser, W. Va.			JAN 7 1969			J. W. Jones		

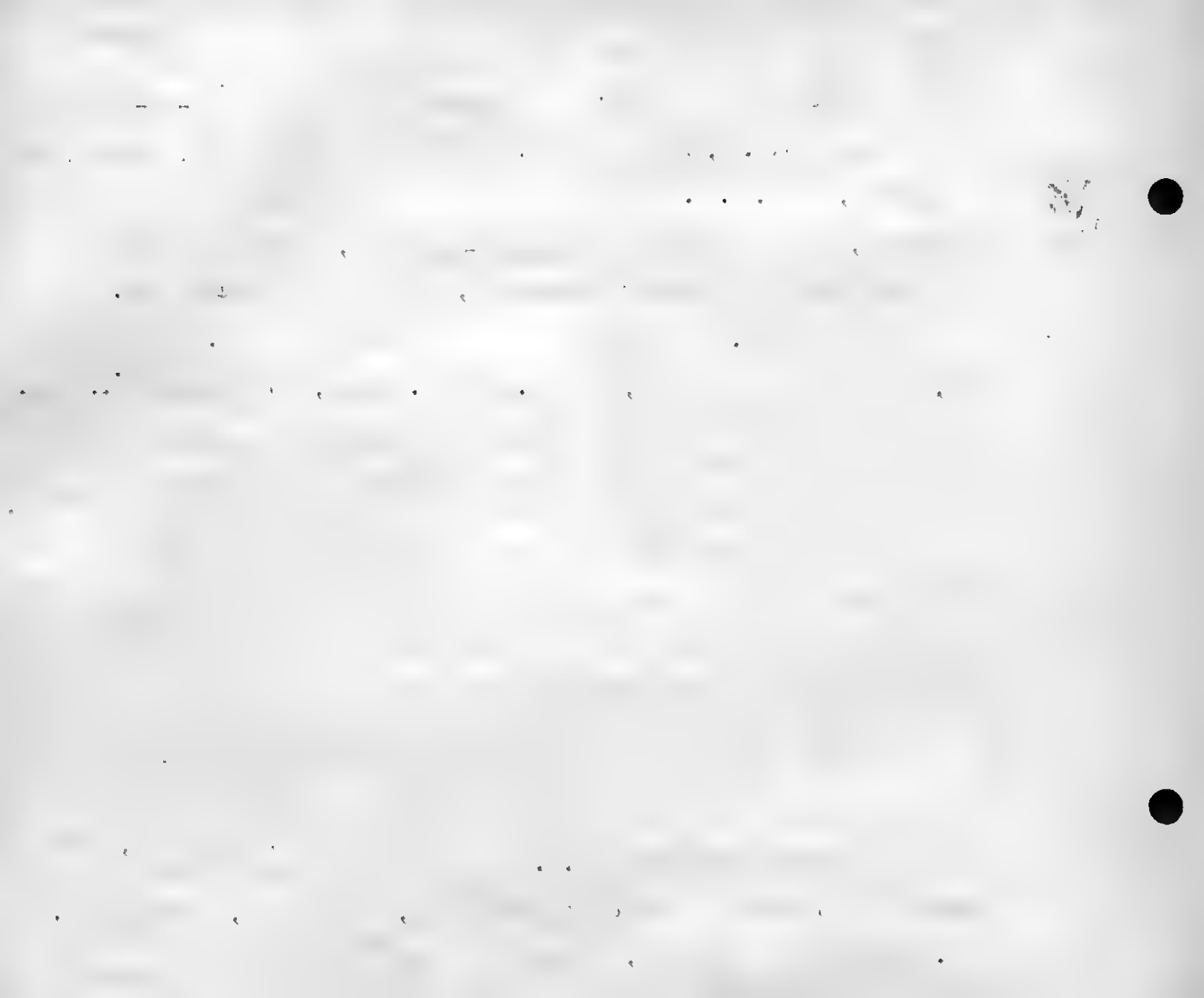


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Mark			Middle Allen			Last Mechem		
3 SEX Male			4 RACE White		5. DATE OF BIRTH Dec. 3, 1968		6 AGE (In years last birthday) 0 YRS		7 UNDER 1 YEAR MONTHS 1 DAYS 18		
7a BIRTHPLACE (State or foreign country) Maryland,			7b CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany		
10. CITY OR TOWN OF DEATH Cumberland,			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital-DOA			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None, Infant			12b KIND OF BUSINESS OR INDUSTRY None		
3a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland			13b COUNTY Allegany			13c CITY OR TOWN Cumberland,			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME Clyde			First D.			Middle Mechem			15 MOTHER'S M A DEN NAME Mary		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No,			16b. SOCIAL SECURITY NO. None,			17. INFORMANT Mr. Clyde D. Mechem,			ADDRESS 531 Patterson Ave. Cumb.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Congestion and Edema										Hours	
DUE TO, OR AS A CONSEQUENCE OF (b) Patent Ductus Arteriosus and Foramen Congenit										al.	
DUE TO, OR AS A CONSEQUENCE OF (c) Ovale											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A M 19 P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic				M.D.				22b. DATE SIGNED January 21, 1969			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, county, state) CUMBERLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 1/23/69				23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park,			
23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.				23e. REC'D BY REG. STAFF JAN 27 1969				23f. REGISTRAR'S SIGNATURE Charles Judge			
24. FUNERAL DIRECTOR H. Wayne George											
ADDRESS Cumberland, Maryland											



CERTIFICATE OF DEATH

00059

00059

1 DECEASED NAME (Type or print) KATHRYN MARIE MICHAELS			2a DATE OF DEATH 1 Month 31 Day 69 Year			2b HOUR P 9:00 M	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH 3/31/22		6 AGE (In years last birthday) 48 YRS	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY	
10. CITY OR TOWN OF DEATH CUMBERLAND		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of year immediately prior to death) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b COUNTY ALLEGANY		13c CITY OR TOWN FROSTBURG		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME WALTER SOLOMAN		15. MOTHER'S MAIDEN NAME MARY ISA SOLOMAN		3e STREET AND NUMBER ROUTE 1 -BOX 621			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO NONE		17. INFORMANT SACRED HEART HOSPITAL		Address 900 SETON DRIVE CUMBERLAND, MD.	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

4 days

24 years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDIT.ON FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from 1-16-1969, to 1-31-1969, that (I) (we) last saw the deceased alive on 1-31-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert Feddis</i>		DEGREE DR. ROBERT FEDDIS		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 500 GREENE STREET -CUMBERLAND, MARYLAND					

23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		2/3/69		PORTER CEMETERY		ECKHART, ALLEGANY, MD.	
24. FUNERAL DIRECTOR MARILOU M. SOWERS		25a. REC'D BY REGISTRAR 5-6 4 1969		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>		HOME, 60 W. MAIN, FROSTBURG	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Item 5 Filed 1/29/69 11w **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 00060

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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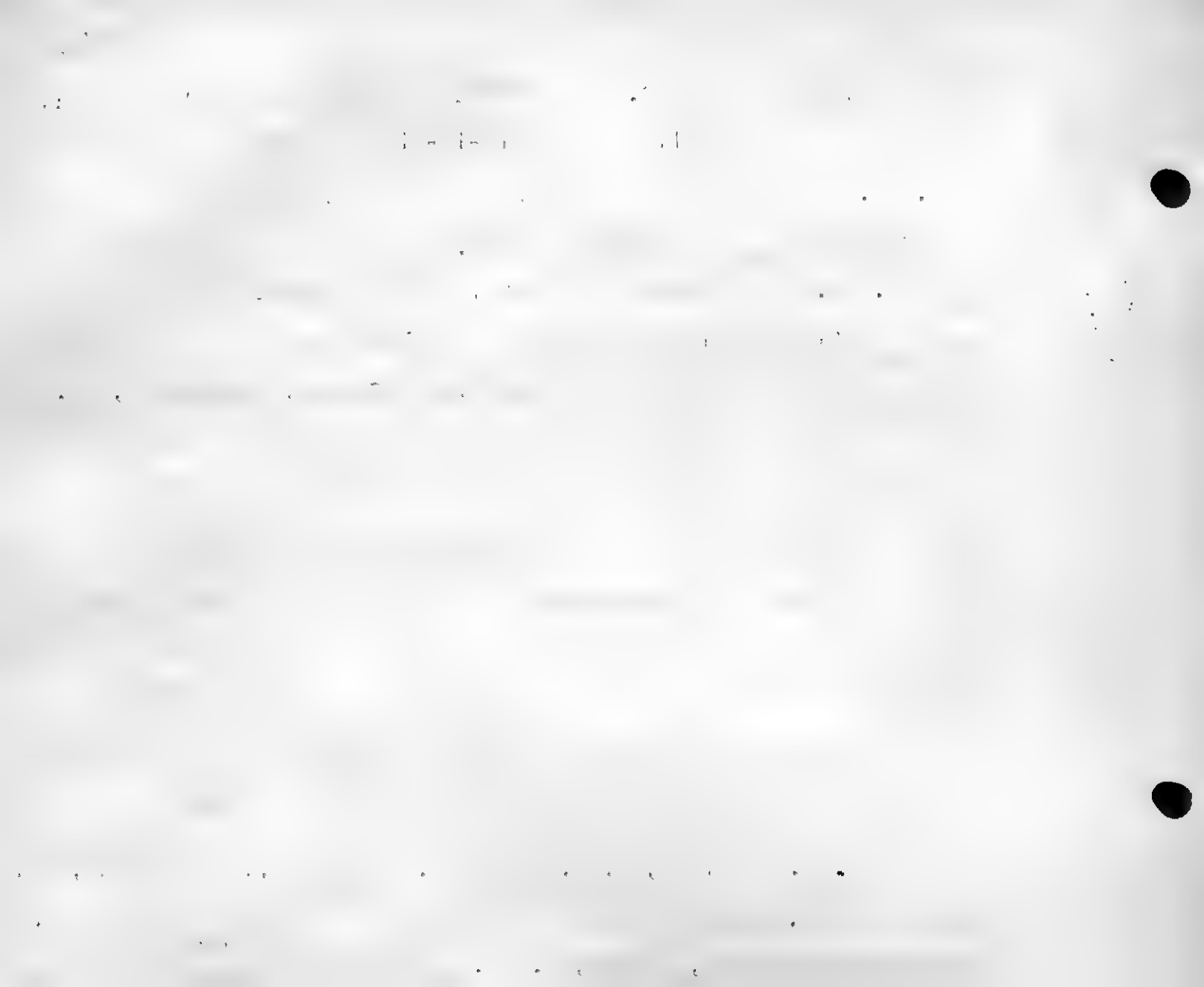
1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED		Month	Day	Year	2b HOUR
LEROY				MILLER	Jan. 22 1969					4P M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 1 YEAR	8 IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		Month	Day	Year
MALE	WHITE	Jan. 22 1968	68 YRS	MONTHS	DAYS	Jan. 22 1969				5P M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH				
PENNA.		USA				ALLEGANY				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND		725 N. Mechanic St.				Retired Fireman		Municipal		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
MD.		ALLEGANY		CUMBERLAND		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		725 N. Mechanic St.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
PERRY			V.	MILLER	RUFFINA WHITACRE					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes and/or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS						
NO				Mr. Harold Miller, Cumberland, Md. Brother						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										SUDDEN
7109 DUE TO, OR AS A CONSEQUENCE OF										
CORONARY OCCLUSION										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
CORONARY SCLEROSIS										
(c) DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
2. a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. P.M. 19								
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		2. e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		BENEDICT SKITARELIC, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED		
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Jan. 22, 1969		
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		
								CUMBERLAND, MARYLAND		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		Jan. 25, 1969		Hyndman Cemetery		Hyndman, Penna.				
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.								JAN 27 1969		



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Then please remove carbon papers 1, 2 and 3 and 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 136 and 137 and 138 and 139 and 140 and 141 and 142 and 143 and 144 and 145 and 146 and 147 and 148 and 149 and 150 and 151 and 152 and 153 and 154 and 155 and 156 and 157 and 158 and 159 and 160 and 161 and 162 and 163 and 164 and 165 and 166 and 167 and 168 and 169 and 170 and 171 and 172 and 173 and 174 and 175 and 176 and 177 and 178 and 179 and 180 and 181 and 182 and 183 and 184 and 185 and 186 and 187 and 188 and 189 and 190 and 191 and 192 and 193 and 194 and 195 and 196 and 197 and 198 and 199 and 200 and 201 and 202 and 203 and 204 and 205 and 206 and 207 and 208 and 209 and 210 and 211 and 212 and 213 and 214 and 215 and 216 and 217 and 218 and 219 and 220 and 221 and 222 and 223 and 224 and 225 and 226 and 227 and 228 and 229 and 230 and 231 and 232 and 233 and 234 and 235 and 236 and 237 and 238 and 239 and 240 and 241 and 242 and 243 and 244 and 245 and 246 and 247 and 248 and 249 and 250 and 251 and 252 and 253 and 254 and 255 and 256 and 257 and 258 and 259 and 260 and 261 and 262 and 263 and 264 and 265 and 266 and 267 and 268 and 269 and 270 and 271 and 272 and 273 and 274 and 275 and 276 and 277 and 278 and 279 and 280 and 281 and 282 and 283 and 284 and 285 and 286 and 287 and 288 and 289 and 290 and 291 and 292 and 293 and 294 and 295 and 296 and 297 and 298 and 299 and 300 and 301 and 302 and 303 and 304 and 305 and 306 and 307 and 308 and 309 and 310 and 311 and 312 and 313 and 314 and 315 and 316 and 317 and 318 and 319 and 320 and 321 and 322 and 323 and 324 and 325 and 326 and 327 and 328 and 329 and 330 and 331 and 332 and 333 and 334 and 335 and 336 and 337 and 338 and 339 and 340 and 341 and 342 and 343 and 344 and 345 and 346 and 347 and 348 and 349 and 350 and 351 and 352 and 353 and 354 and 355 and 356 and 357 and 358 and 359 and 360 and 361 and 362 and 363 and 364 and 365 and 366 and 367 and 368 and 369 and 370 and 371 and 372 and 373 and 374 and 375 and 376 and 377 and 378 and 379 and 380 and 381 and 382 and 383 and 384 and 385 and 386 and 387 and 388 and 389 and 390 and 391 and 392 and 393 and 394 and 395 and 396 and 397 and 398 and 399 and 400 and 401 and 402 and 403 and 404 and 405 and 406 and 407 and 408 and 409 and 410 and 411 and 412 and 413 and 414 and 415 and 416 and 417 and 418 and 419 and 420 and 421 and 422 and 423 and 424 and 425 and 426 and 427 and 428 and 429 and 430 and 431 and 432 and 433 and 434 and 435 and 436 and 437 and 438 and 439 and 440 and 441 and 442 and 443 and 444 and 445 and 446 and 447 and 448 and 449 and 450 and 451 and 452 and 453 and 454 and 455 and 456 and 457 and 458 and 459 and 460 and 461 and 462 and 463 and 464 and 465 and 466 and 467 and 468 and 469 and 470 and 471 and 472 and 473 and 474 and 475 and 476 and 477 and 478 and 479 and 480 and 481 and 482 and 483 and 484 and 485 and 486 and 487 and 488 and 489 and 490 and 491 and 492 and 493 and 494 and 495 and 496 and 497 and 498 and 499 and 500 and 501 and 502 and 503 and 504 and 505 and 506 and 507 and 508 and 509 and 510 and 511 and 512 and 513 and 514 and 515 and 516 and 517 and 518 and 519 and 520 and 521 and 522 and 523 and 524 and 525 and 526 and 527 and 528 and 529 and 530 and 531 and 532 and 533 and 534 and 535 and 536 and 537 and 538 and 539 and 540 and 541 and 542 and 543 and 544 and 545 and 546 and 547 and 548 and 549 and 550 and 551 and 552 and 553 and 554 and 555 and 556 and 557 and 558 and 559 and 560 and 561 and 562 and 563 and 564 and 565 and 566 and 567 and 568 and 569 and 570 and 571 and 572 and 573 and 574 and 575 and 576 and 577 and 578 and 579 and 580 and 581 and 582 and 583 and 584 and 585 and 586 and 587 and 588 and 589 and 590 and 591 and 592 and 593 and 594 and 595 and 596 and 597 and 598 and 599 and 600 and 601 and 602 and 603 and 604 and 605 and 606 and 607 and 608 and 609 and 610 and 611 and 612 and 613 and 614 and 615 and 616 and 617 and 618 and 619 and 620 and 621 and 622 and 623 and 624 and 625 and 626 and 627 and 628 and 629 and 630 and 631 and 632 and 633 and 634 and 635 and 636 and 637 and 638 and 639 and 640 and 641 and 642 and 643 and 644 and 645 and 646 and 647 and 648 and 649 and 650 and 651 and 652 and 653 and 654 and 655 and 656 and 657 and 658 and 659 and 660 and 661 and 662 and 663 and 664 and 665 and 666 and 667 and 668 and 669 and 670 and 671 and 672 and 673 and 674 and 675 and 676 and 677 and 678 and 679 and 680 and 681 and 682 and 683 and 684 and 685 and 686 and 687 and 688 and 689 and 690 and 691 and 692 and 693 and 694 and 695 and 696 and 697 and 698 and 699 and 700 and 701 and 702 and 703 and 704 and 705 and 706 and 707 and 708 and 709 and 710 and 711 and 712 and 713 and 714 and 715 and 716 and 717 and 718 and 719 and 720 and 721 and 722 and 723 and 724 and 725 and 726 and 727 and 728 and 729 and 730 and 731 and 732 and 733 and 734 and 735 and 736 and 737 and 738 and 739 and 740 and 741 and 742 and 743 and 744 and 745 and 746 and 747 and 748 and 749 and 750 and 751 and 752 and 753 and 754 and 755 and 756 and 757 and 758 and 759 and 760 and 761 and 762 and 763 and 764 and 765 and 766 and 767 and 768 and 769 and 770 and 771 and 772 and 773 and 774 and 775 and 776 and 777 and 778 and 779 and 780 and 781 and 782 and 783 and 784 and 785 and 786 and 787 and 788 and 789 and 790 and 791 and 792 and 793 and 794 and 795 and 796 and 797 and 798 and 799 and 800 and 801 and 802 and 803 and 804 and 805 and 806 and 807 and 808 and 809 and 810 and 811 and 812 and 813 and 814 and 815 and 816 and 817 and 818 and 819 and 820 and 821 and 822 and 823 and 824 and 825 and 826 and 827 and 828 and 829 and 830 and 831 and 832 and 833 and 834 and 835 and 836 and 837 and 838 and 839 and 840 and 841 and 842 and 843 and 844 and 845 and 846 and 847 and 848 and 849 and 850 and 851 and 852 and 853 and 854 and 855 and 856 and 857 and 858 and 859 and 860 and 861 and 862 and 863 and 864 and 865 and 866 and 867 and 868 and 869 and 870 and 871 and 872 and 873 and 874 and 875 and 876 and 877 and 878 and 879 and 880 and 881 and 882 and 883 and 884 and 885 and 886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000.

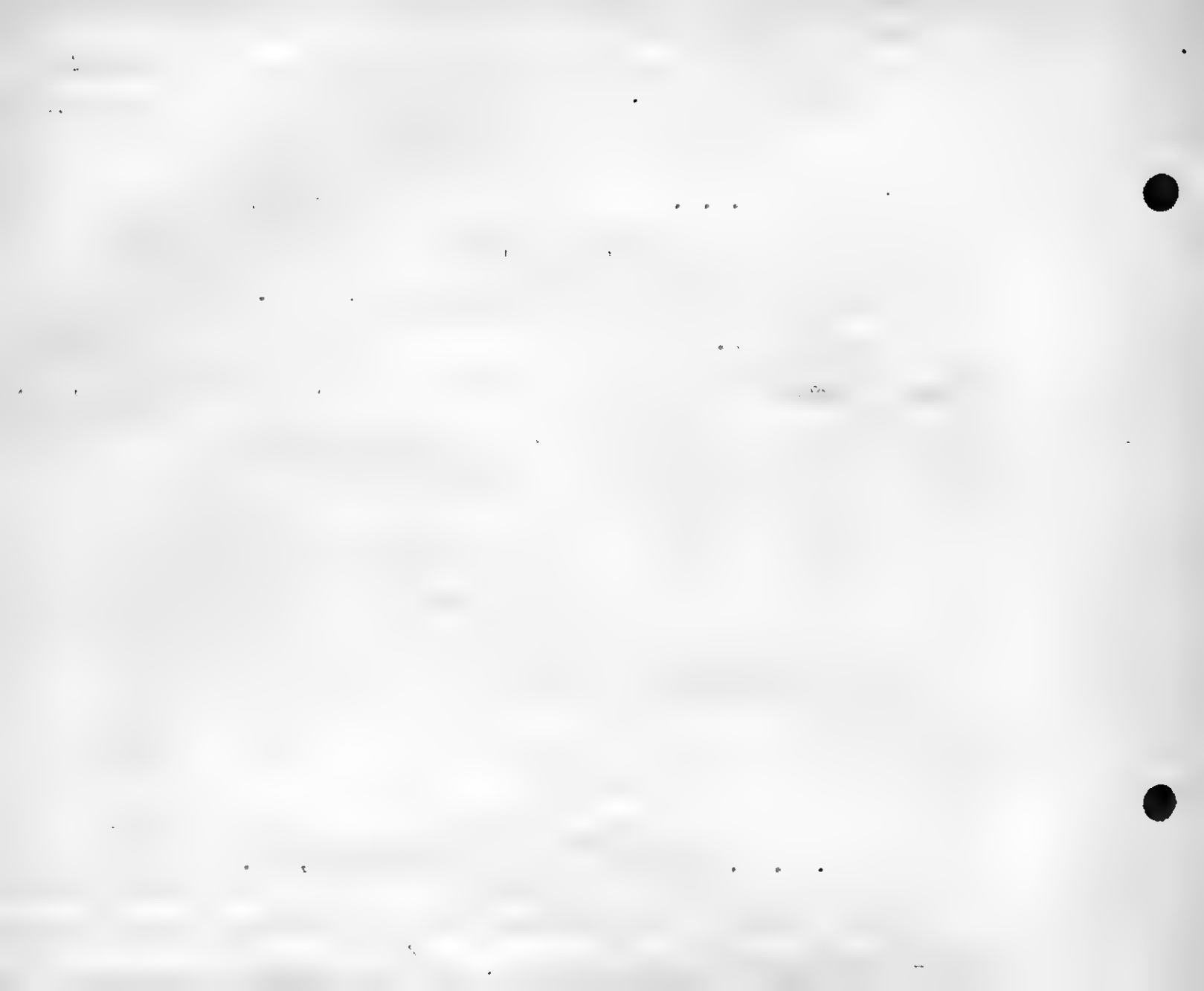
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR A		
ISAAC			S.		MORELAND	JANUARY 20 1969		3:10 M		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE		WHITE		10-19-81		87 YRS.				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
W. VA.		USA				ALLEGANY				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND		MEMORIAL HOSP.				FARMER		FARM		
13a USUA. RESIDENCE (Where deceased lived if institution residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
W. VA.		MINERAL		RIDGELEY				ROUTE #1		
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last	
BASIL			NEWTON	MORELAND		RHODA			WHITACRE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT				Address	
NO			236-58-1129		MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>dis. years</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>10-18-1968</u> , to <u>1-20-1969</u> , that (I) (we) last saw the deceased alive on <u>1-19-1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)				
<u>Wm. F. Williams</u>		1-20-69				W. F. WILLIAMS, M. D.				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		Jan. 23, 1969		Levels		Levels Hampshire W. Va.				
24. FUNERAL DIRECTOR					ADDRESS		25a. RECEIVED BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
SHAFFER FUNERAL HOME, ROMNEY, W. VA.							JAN 24 1969		<u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First WILBERT		Middle L.		Last MOWEN		2a. DATE OF DEATH Month 1 Day 7 Year 69			2b. HOUR 7:20A
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 4-29-83			6 AGE (in years last birthday) 85 YRS		7 UNDER 24 HRS MONTHS DAYS		8 UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY					
10. CITY OR TOWN OF DEATH CUMBERLAND		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED * B & O Employee			12b. KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN FLINTSTONE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT. 2			
14 FATHER'S NAME First DAVID		Middle F.		Last MOWEN		15. MOTHER'S M.A.D.E.N NAME First VIRGINIA		Middle HOUCK		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. NO		17 INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Heart Failure Secondary to heart disease 485X DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Bronchial asthma											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 1/1/69 , to 1/7/69 , that (I) (we) last saw the deceased alive on 1/6/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (do) (did not) view the body after death.											
22b. SIGNATURE S. G. Weisman		22c. DATE SIGNED 1/8/69		22d. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		22e. ADDRESS CUMBERLAND, MD.		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22g. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/9/69		23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery		23d. LOCATION (City or Town) Cumberland Allegany Maryland		23e. REGISTRAR'S SIGNATURE Charles J. J...		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR Silcox-Merritt Funeral Service, Cumberland, Md		ADDRESS		25a. REC'D BY REG. STRAR 10 1969		25b. REGISTRAR'S SIGNATURE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH			2b HOUR
ANNA			MAE	NEILSON	Month 01 Day 10 Year 69			4:25 PM	
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 IF UNDER YEAR MONTHS DAYS	
FEMALE	WHITE		11-03-95			73 YRS			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
WEST VIRGINIA			U.S.A.				ALLEGANY COUNTY, MD		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of last year or if retired)		12b KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND			SACRED HEART HOSPITAL			HOUSEWIFE			
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
MARYLAND			ALLEGANY		FROSTBURG		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		259 WELCH HILL
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME First Middle Last			
THOMAS			DAVIS			(EISENTROUT) CLEMMIE DAVIS			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT				
			213-09-6427		SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) Hypostatic Pneumonia									3 days
DUE TO OR AS A CONSEQUENCE OF									
(b) Congestive heart failure									8 days
DUE TO OR AS A CONSEQUENCE OF									
(c) Hypertensive arteriosclerosis C.V.H.D.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Carcinoma left breast capillary metastases									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
12/30/68			Cancer left breast						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			HOUR A.M. Month Day Year						
			P.M. 19						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12/27, 1968, to 1/10, 1969, that (I) (we) lost saw the deceased alive on 1/9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
Thomas F. Lewis M.D.								1/11/69	
22d PHYSICIAN'S NAME (Type)						22e ADDRESS			
T.F. LEWIS, M.D.						500 GREENE ST., CUMB., MD. 21502			
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
BURIAL			1-12-1969		FROSTBURG MEMORIAL PARK FROSTBURG, ALLEG. MD.				
24 FUNERAL DIRECTOR						25a REG'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
DURST FUNERAL HOME, 57 FROST AVE., FROST., MD.						JAN 16 1969		[Signature]	

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

30064

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

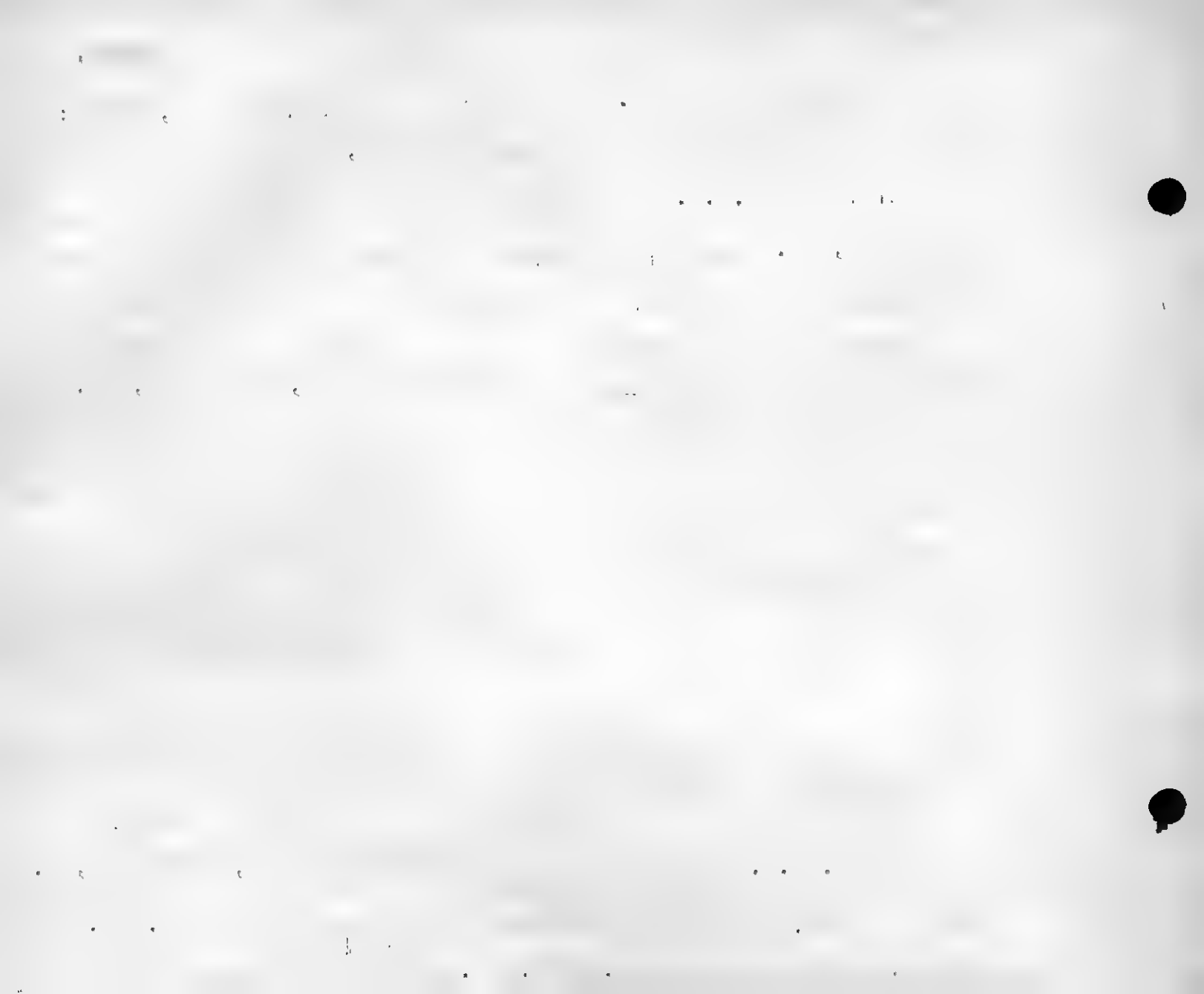
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| | | | | | | | | | | | |
|---|--|---|---|--|--|--|--|--|--|--|--------------------------------|
| 1 DECEASED-NAME
(Type or print) SARA | | | First Middle Last
(WELLINGS) NEILSON | | | 2a. DATE OF DEATH
Month JANUARY Day 3 , Year 1969 | | | 2b. HOUR
2:00 AM | | |
| 3. SEX
FEMALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
AUGUST 1, 1908 | | | 6 AGE (In years last birthday)
60 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
ALLEGANY Md | | | | | |
| 10 CITY OR TOWN OF DEATH
FROSTBURG | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ROUTE 1 | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSE WORK | | | 12b KIND OF BUSINESS OR INDUSTRY
OWN HOME | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY
ALLEGANY | | | 13c. CITY OR TOWN
FROSTBURG | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
RT. 1, BOX 51 | |
| 14 FATHER'S NAME
First Middle Last
GEORGE WELLINGS | | | 15 MOTHER'S MAIDEN NAME
First Middle Last
JULIA RAE | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT
MARSHALL NEILSON, RT. 1, FROSTBURG, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Myocardial fibrillation</u> | | | | | | | | | | | |
| 412a DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) <u>Hypertensive cardiovascular disease</u> 12 yrs. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) <u>Generalized arteriosclerosis</u> 18 yrs. | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:(c) | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)
OFFICE, BUILDING, ETC. | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a I certify that (I) (the hospital) attended the deceased from <u>November 1959</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>Dec 12 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Alvin J. Walters MD</u> | | | | | | DEGREE
ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>1/3/68</u> | | |
| 22d. PHYSICIAN'S NAME (Type)
ALVIN J. WALTERS, M. D. | | | | | | 22e. ADDRESS
48 BROADWAY, FROSTBURG, MD. 21532 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
JAN. 5, 1969 | | | 23c. NAME OF CEMETERY OR CREMATORY
FBG. MEMORIAL PARK | | | 23d. LOCATION (City or Town) (County) (State)
FROSTBURG, MD. | | |
| 24 FUNERAL DIRECTOR
JOSEPH R. DURST, FROSTBURG, MD. 21532 | | | | | | 25a. RECORD REGISTRATION
JAN 7 1969 | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | First
SIMON | | Middle
P. | | Last
NEWLIN | | 2a. DATE OF DEATH
Month Day Year
JANUARY 12, 1969 | | 2b. HOUR
5:55AM |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
SEPTEMBER 15, 1876 | | 6. AGE (in years last birthday)
92 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS | | 8. UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
ALLEGANY | | Md. | | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND, MD. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Guard | | 12b. KIND OF BUSINESS OR INDUSTRY
Electric | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
MARYLAND | | 13b. COUNTY
ALLEGANY | | 13c. CITY OR TOWN
CUMBERLAND | | 13d. INSIDE CITY, M.F.S?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
551 WINIFRED ROAD | | |
| 14. FATHER'S NAME
First Middle Last
JOHN | | 15. MOTHER'S MAIDEN NAME
First Middle Last
CLARA Highby HIGHER | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or Unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO
217-10-9460 | | 17. INFORMANT
Address
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | | | |
| 18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia | | | | | | | | | | 4 days |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | 5 yrs. |
| (b) General arteriosclerosis | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Benign hypertrophy of prostate - obstructive | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1950 , to 1/12, 1969 , that (I) (we) lost saw the deceased alive on 1/11, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
S. G. Weisman | | 22c. DEGREE
MD | | ATTENDING PHYS.
<input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22e. DATE SIGNED
1/14/69 |
| 22d. PHYSICIAN'S NAME (Type)
DR. S.G. WEISMAN | | 22e. ADDRESS
59 GREENE STREET, CUMBERLAND, MD. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 14, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Philos Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Westernport, Alleg., Md. | | | | |
| 24. FUNERAL DIRECTOR
Philip B. Wendt | | ADDRESS
121 Memorial Ave., Cumb., Md. | | 25a. REC'D BY REGISTRAR
JAN 16 1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | |

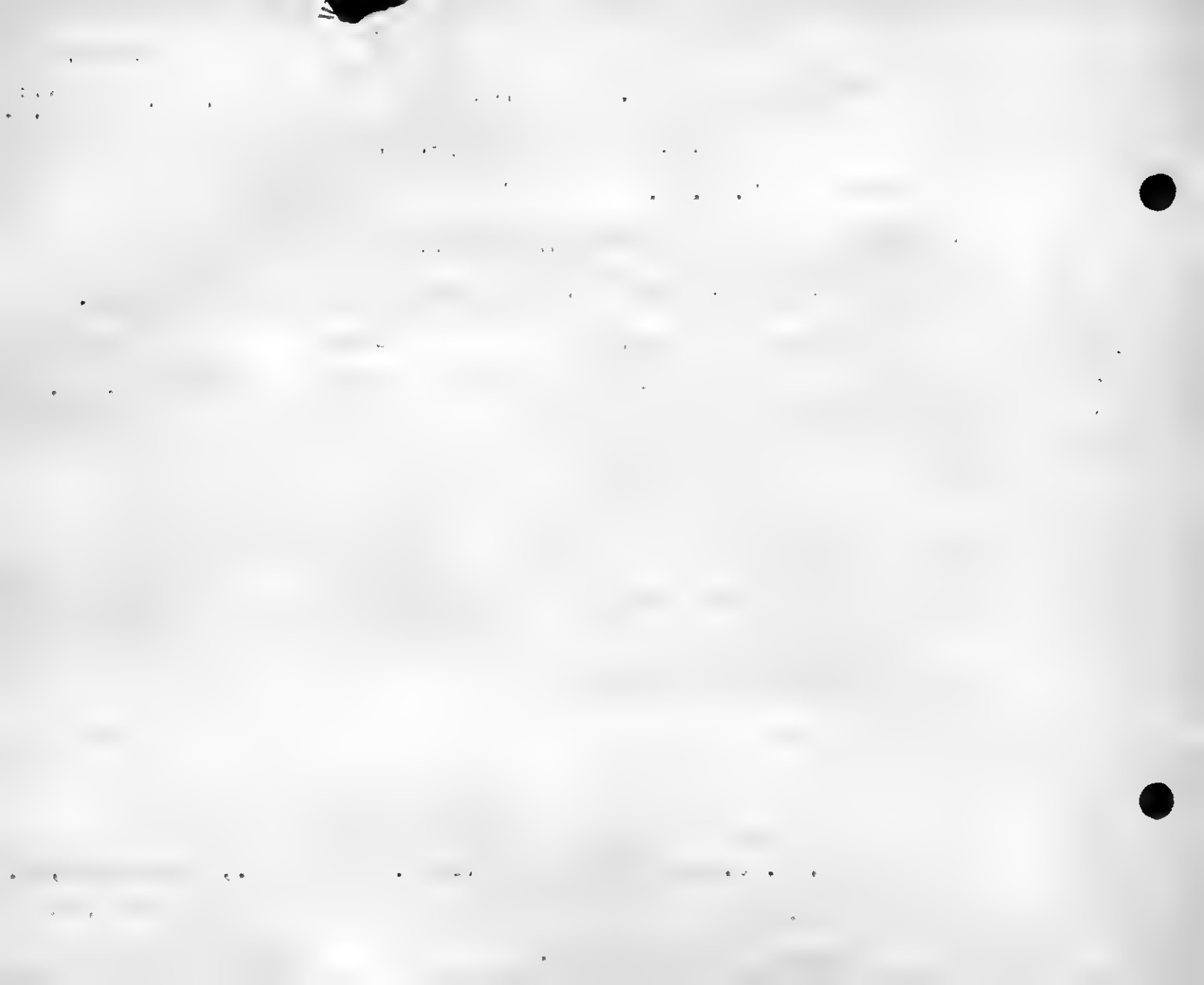


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| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1 DECEASED NAME (Type or print) SAMUEL First A. Middle NICHOLS Last | | | | 2a. DATE OF DEATH Month 1 Day 1 Year 69 | | | | 2b. HOUR 11:30 A.M. | | | |
| 3 SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH 8-17-1901 | | 6 AGE (in years last birthday) 67 YRS. | | 7 UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) MARYLAND | | 7b CITIZEN OF WHAT COUNTRY? U. S. A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH ALLEGANY | | | | | |
| 10 CITY OR TOWN OF DEATH CUMBERLAND | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL - R. Blacksmith H. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY Railroad | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND | | 13b COUNTY ALLEGANY | | 13c CITY OR TOWN CUMBERLAND | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 514 WOODSIDE AVE. | | | |
| 14 FATHER'S NAME First BENJAMIN Middle Last NICHOLS | | | | 15. MOTHER'S MAIDEN NAME First SARAH Middle Last MC GEE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO A705-07-9629 | | 17 INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD. Address | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Heart Attack DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day 19 Year 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town Cumberland County Allegany State MD | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/2/69 , 19 19 , to 1/2/69 , 19 19 , that (I) (we) last saw the deceased alive on 1/1/69 , 19 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE DR. R. J. WILLIAMS | | 22c. DATE SIGNED 1/2/69 | | 22d. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS | | 22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD. | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Jan. 4, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park | | 23d. LOCATION (City or Town) Cumberland (County) Allegany (State) MD. | | | | | |
| 24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md. | | 25a. REC'D BY REGISTRAR JAN 7 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | |

VERIFIED
1/2/69



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

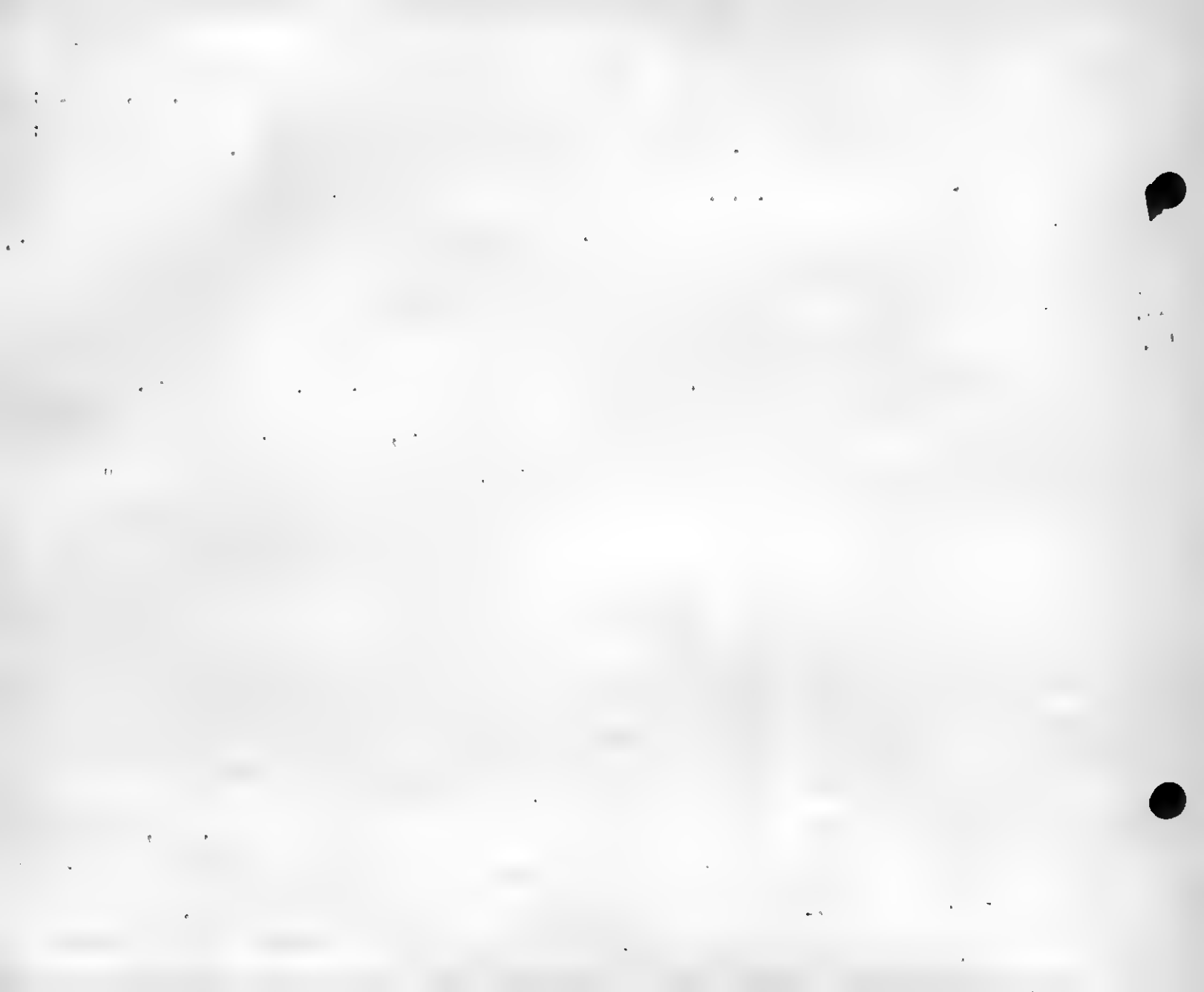
| | | | | | | | | | | | |
|--|--|---|---|--|--|---|---|---------------------------------|----------------------------------|--|--|
| 1 DECEASED NAME
(Type or print) | | | First | Middle | Last | 2a DATE OF DEATH | | | 2b HOUR | | |
| MYRTLE M. OBERLY | | | | | | 1 Month 2 Day 69 Year | | | 3:00 PM | | |
| 3. SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| FEMALE | | WHITE | | 4/2/96 | | 72 YRS. | | MONTHS DAYS | | HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| WEST VIRGINIA | | USA | | | | ALLEGANY Md | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| CUMBERLAND | | | SACRED HEART HOSPITAL | | | HOUSEWIFE | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | | |
| MARYLAND | | | ALLEGANY | | WESTERNPORT | | | | 115 GREENE STREET | | |
| 14 FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| CONNOR SHILLINGBURG | | | EMMA HALL SHILLINGBURG | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT | | | Address | | | |
| NO | | | 234 03 2668 | | SACRED HEART HOSPITAL | | | 900 SETON DRIVE CUMBERLAND, MD. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>coronary artery disease</u> | | | | | | | | | | 3 years | |
| 4123 DUE TO, OR AS A CONSEQUENCE OF (b) <u>generalized arteriosclerosis</u> | | | | | | | | | | 3 years | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-6-1968 to 1-2-1969, that (I) (we) last saw the deceased alive on 1-2-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b SIGNATURE <u>Lewis Brings M.D.</u> | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c DATE SIGNED 1-3-69 | | | | |
| 22d PHYSICIAN'S NAME (Type) DR. LEWIS BRINGS | | | | | 22e ADDRESS 57 GREENE ST - CUMBERLAND, MD. 21502 | | | | | | |
| 23a BURIAL CREMATION (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or town) (County) (State) | | | | |
| Burial | | 1/6/69 | | Philos | | | Westernport, Md | | | | |
| 24 FUNERAL DIRECTOR <u>E. S. Boal</u> | | | | | ADDRESS | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | |
| BOAL'S FUNERAL HOME - 1111 CHURCH STREET WESTERNPORT, MD - 21562 | | | | | | | JAN 10 1969 | | <u>Charles Judge</u> | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give P.O.s as 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
|---|-------------------------|--|--|---|--|---|---|---|---|---|---|---|--------------------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or Print) | | | First
CHARLES | | | Middle
H. | | | Last
OWENS | | | 2a. DATE KNOWN OF DEATH
<input checked="" type="checkbox"/> Month Day Year
JAN. 31, 1969 | 2b. HOUR
11:30 |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
SEPT. 18, 1909 | | 6. AGE (In years last birthday)
59 YRS | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | | 2c. DATE PRONOUNCED DEAD
Month Day Year
JAN. 31 1969 | | 2d. HOUR
11:30 | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
ALLEGANY | | | | | | | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
DOR SACRED HEART HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
FILTRATION | | | 12b. KIND OF BUSINESS OR INDUSTRY
CELANESE CORP. | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE
MARYLAND | | | 13b. COUNTY
ALLEGANY | | 13c. CITY OR TOWN
FROSTBURG | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
ROUTE 1 | | | | |
| 14. FATHER'S NAME
First Middle Last
CHARLES H. OWENS | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
NELLIE CAMPBELL | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
NO | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
214-07-4685 | | 17. INFORMANT
ADDRESS
NELLIE OWENS, RT. 1, FROSTBURG, MD. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis, generalized
DUE TO, OR AS A CONSEQUENCE OF
Carcinoma of Liver
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Months | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M.
19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Benedict Skitarolic</i> | | | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D. | | | | 22b. DATE SIGNED
Jan. 31, 1969 | | ADDRESS (Street, city, town, or county) RD 9, CUMBERLAND, MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
2-3-69 | | 23c. NAME OF CEMETERY OR CREMATORY
FBG. MEMORIAL PARK | | | 23d. LOCATION (City or Town) (County) (State)
FROSTBURG, MD. | | | | | | |
| 24. FUNERAL DIRECTOR
J. R. DURST, FROSTBURG, MD. 21532 | | | | ADDRESS | | 25a. RECEIVED BY REGISTRAR
DATE
FEB 4 1969 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 174
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00069

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME (Type or print) CHARLES | | | First Middle Last FRANKLIN PAINTER | | | 2a. DATE OF DEATH
Month 1 Day 6 Year 69 | | | 2b. HOUR 10:15 AM | | |
| 3. SEX MALE | | | 4. RACE WHITE | | | 5. DATE OF BIRTH 3-7-99 | | | 6. AGE (In years birthday) 69 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) VA. | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH ALLEGANY | | |
| 10. CITY OR TOWN OF DEATH CUMBERLAND, | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DAVIS MEMORIAL HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during last 12 months, or life, even if retired) Tire room worker | | | 12b. KIND OF BUSINESS OR INDUSTRY Kelly Tire | | |
| 13a. USLA. RESIDENCE (Where deceased lived, if institution Residence before admission) MARYLAND | | | 13b. ALLEGANY | | | 13c. CITY OR TOWN CUMBERLAND | | | 13d. INS. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME First Middle Last BARNEY PAINTER | | | 15. MOTHER'S MAIDEN NAME First Middle Last JANE A. Longerbean | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO | | | 16b. SOCIAL SECURITY NO. 220-03-7439 | | |
| 17. INFORMANT Mrs. Gladys M. Painter | | | 17a. ADDRESS CUMBERLAND, Md. | | | 17b. STREET AND NUMBER 122 Polk St. | | | 17c. CITY AND STATE Cum. Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) pneumonia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
pulmonary emphysema | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21a. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21c. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-4- , 19 69 , to 1-6- , 19 69 , that (I) (we) last saw the deceased alive on 1-6- , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE L. Brings | | | 22c. DATE SIGNED 1-8-69 | | | 22d. PHYSICIAN'S NAME (Type) DR. L. BRINGS | | | 22e. ADDRESS 57 Greene St. Cumberland, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE 1/9/69 | | | 23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md. | | |
| 24. FUNERAL DIRECTOR GEORGES H. Wayne | | | ADDRESS George Cumberland, Md. | | | 25a. REC'D BY REGISTRAR JAN 10 1969 | | | 25b. REGISTRAR'S SIGNATURE Charles Yager | | |

1. The first part of the report is a general introduction to the subject.

-5-

2. The second part is a detailed description of the methods used.

3. The third part is a discussion of the results obtained.

4. The fourth part is a conclusion and a list of references.

5. The fifth part is a summary of the work.

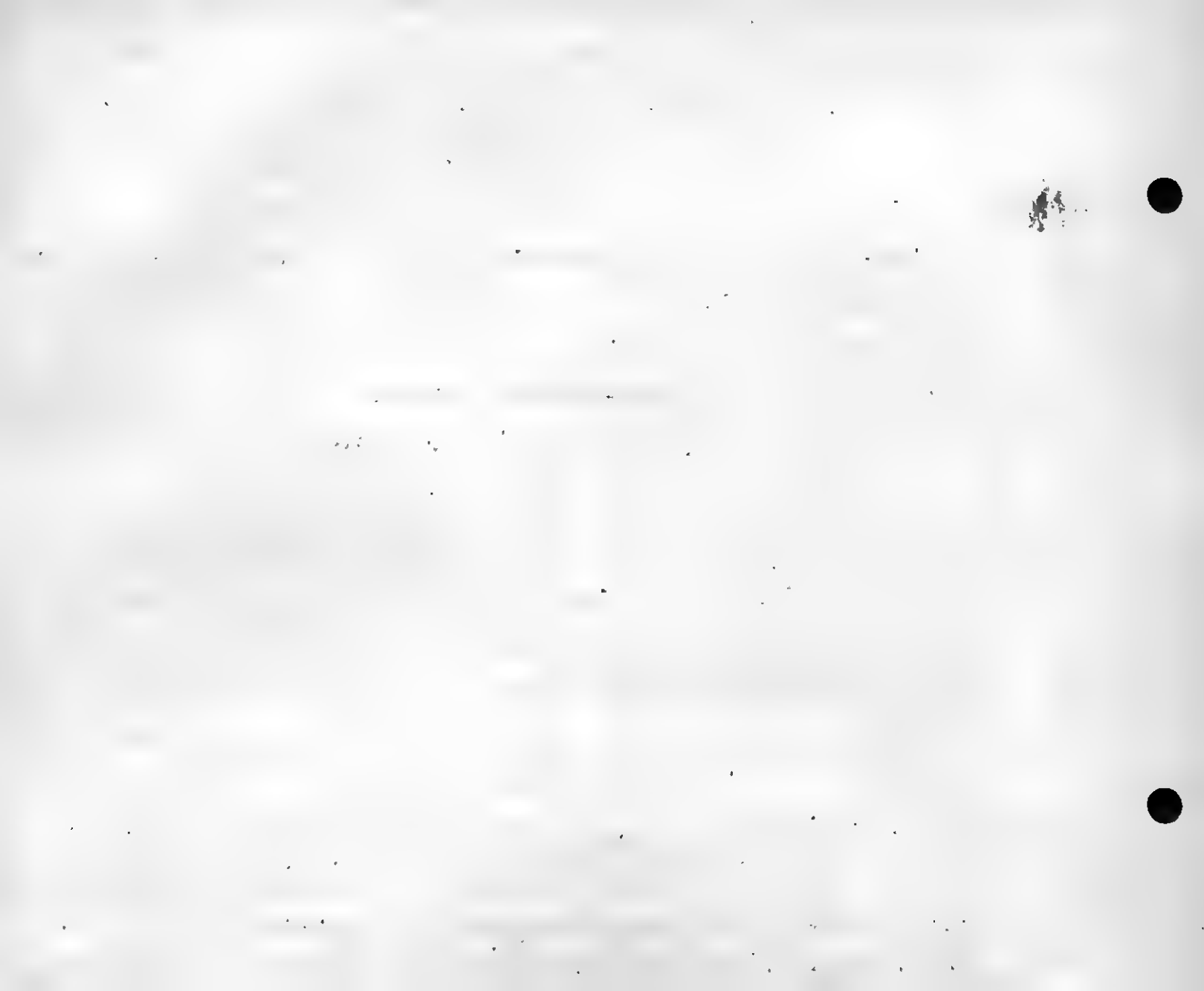
6. The sixth part is a list of the authors.

7. The seventh part is a list of the titles.

8.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

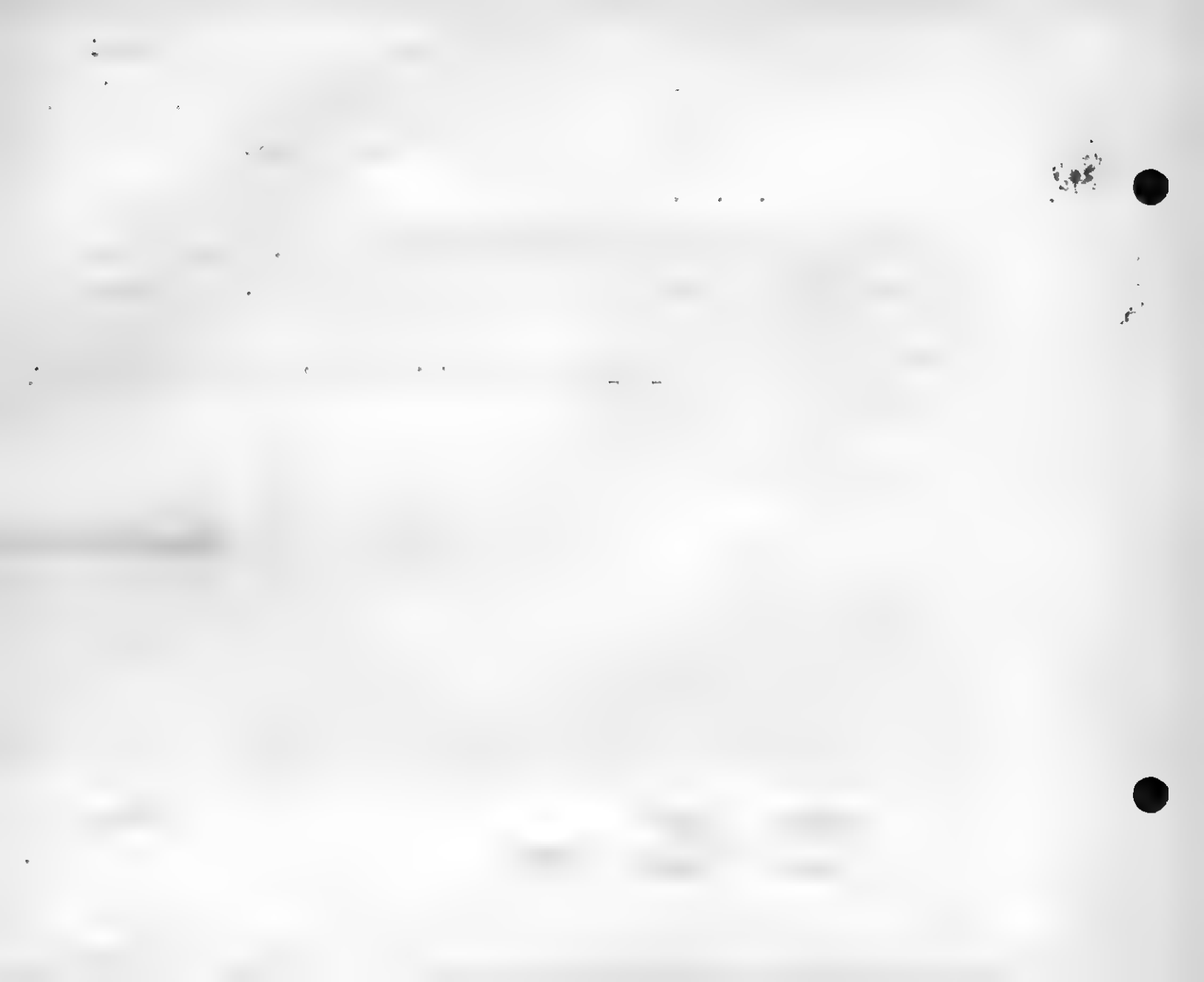
| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|-------|--|
| Item 13e Film G DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
1/29/69 llw Item#13e, Film G 109 2 | | | | | | | | | | 00670 | |
| 1 DECEASED NAME (Type or print)
First Middle Last
John Frederick Perdw | | | 2a. DATE OF DEATH
Month Day Year
January 22 1969 | | | 2b HOUR
M | | | | | |
| 3 SEX
Male | | 4. RACE
White | | 5 DATE OF BIRTH
Dec. 9, 1906 | | 6 AGE (In years last birthday)
62 YRS | | 7 IF UNDER YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 COUNTY OF DEATH
Allegany Md | | | | | |
| 10 CITY OR TOWN OF DEATH
Lonaconing | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Kyle Nursing Home | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Meat Cutter | | 12b KIND OF BUSINESS OR INDUSTRY
Judy's Market | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
STATE Maryland | | 13b. COUNTY
Allegany | | 13c. CITY OR TOWN
Cumberland | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
881 Jackson Columbia St. | | | |
| 14 FATHER'S NAME First Middle Last
John M Perdw | | | 15 MOTHER'S MAIDEN NAME First Middle Last
Nellie Cessna | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | 16b SOCIAL SECURITY NO.
(If yes give war or dates of service)
214-05-8586 | | 17 INFORMANT
Ann Perdw | | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Pulmonary Hemorrhage
517X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Pulmonary Fibrosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Generalized Enterocolitis | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
— | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 23, 1969, to Jan. 27, 1969, that (I) (we) lost the deceased alive on Jan. 27, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
L.R. Miles, Jr. | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/24-69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
L.R. MILES, JR., M.D. | | | | 22e. ADDRESS
LONA CONING MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1/25/1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Rosehill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Cumberland Alleg Md. | | | | | |
| 24. FUNERAL DIRECTOR
John J. Hafer, Jr., 230 Balto Ave. Cumberland Md. | | | | 25a. REC'D BY REGISTRAR
JAN 27 1969 | | 25b. REGISTRAR'S SIGNATURE
f Charles Judge | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to separate papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 00071 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 00071 | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-----------------------------------|--|--|--|--|-----------------------------------|--|--|--|--|------------------|--|--|--|--|
| Item 8 Film 409 2/7/69 kk | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | First
John | | | | | Middle
Gilbert | | | | | Last
Pfaff | | | | | 2a. DATE OF DEATH @
Month
January | | | | | 3:10 P.M.
Day
25 | | | | | Year
1969 | | | | | 2b. HOUR
P.M. | | | | |
| 3 SEX
Male | | | | | 4 RACE
White | | | | | 5. DATE OF BIRTH
7/16/1899 | | | | | 6. AGE (In years
last birthday)
69 | | | | | YRS. | | | | | IF UNDER 1 YEAR
MONTHS
DAYS | | | | | IF UNDER 24 HRS.
HOURS
MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
Maryland | | | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
Allegany County Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Cumberland | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Allegany County Infirmary | | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Male Pract. Nurse | | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Hospital | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before
admission) STATE
Maryland | | | | | 13b. COUNTY
Allegany | | | | | 13c. CITY OR TOWN
Frostburg | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER
200 E. Main Street | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
First
Gilbert | | | | | Middle
Pfaff | | | | | Last
Pfaff | | | | | 15. MOTHER'S MAIDEN NAME
First
Sara | | | | | Middle
Saurbaugh | | | | | Last
Saurbaugh | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | | | | 16b. SOCIAL SECURITY NO
(If yes give war or dates of service)
400-12-0716 | | | | | 17. INFORMANT
P.O. Box 599,
Allegany County Infirmary records. | | | | | Address
Cumberland Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocarditis</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Chronic A.S.H.D. & Hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Atherosclerosis</u>
CONDITIONS, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
7 days | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Coronary thrombosis - myocardial infarction 10/6/66 coronary occlusion 1/67</u> | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner)
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/14/1967, to 1/25/1969, that (I) (we) lost
saw the deceased alive on 1/25/1969, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
John A. Topper | | | | | | | | | | DEGREE
ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED
1-28-69 | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type)
John A. Topper M.D. | | | | | | | | | | 22e. ADDRESS
Memorial Hospital, Cumberland, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL | | | | | 23b. DATE
JAN. 27, 1969 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
FROSTBURG MEM. PARK | | | | | 23d. LOCATION (City or Town) (County) (State)
FROSTBURG, ALLEGANY, MD. | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Marilyn M. Sowers | | | | | | | | | | ADDRESS
SOUTHERN FARMERS FUNERAL HOME, 60 W. ALI, FROSTBURG | | | | | 25a. REC'D BY REGISTRAR
FEB 3 1969 | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | | | | | | |



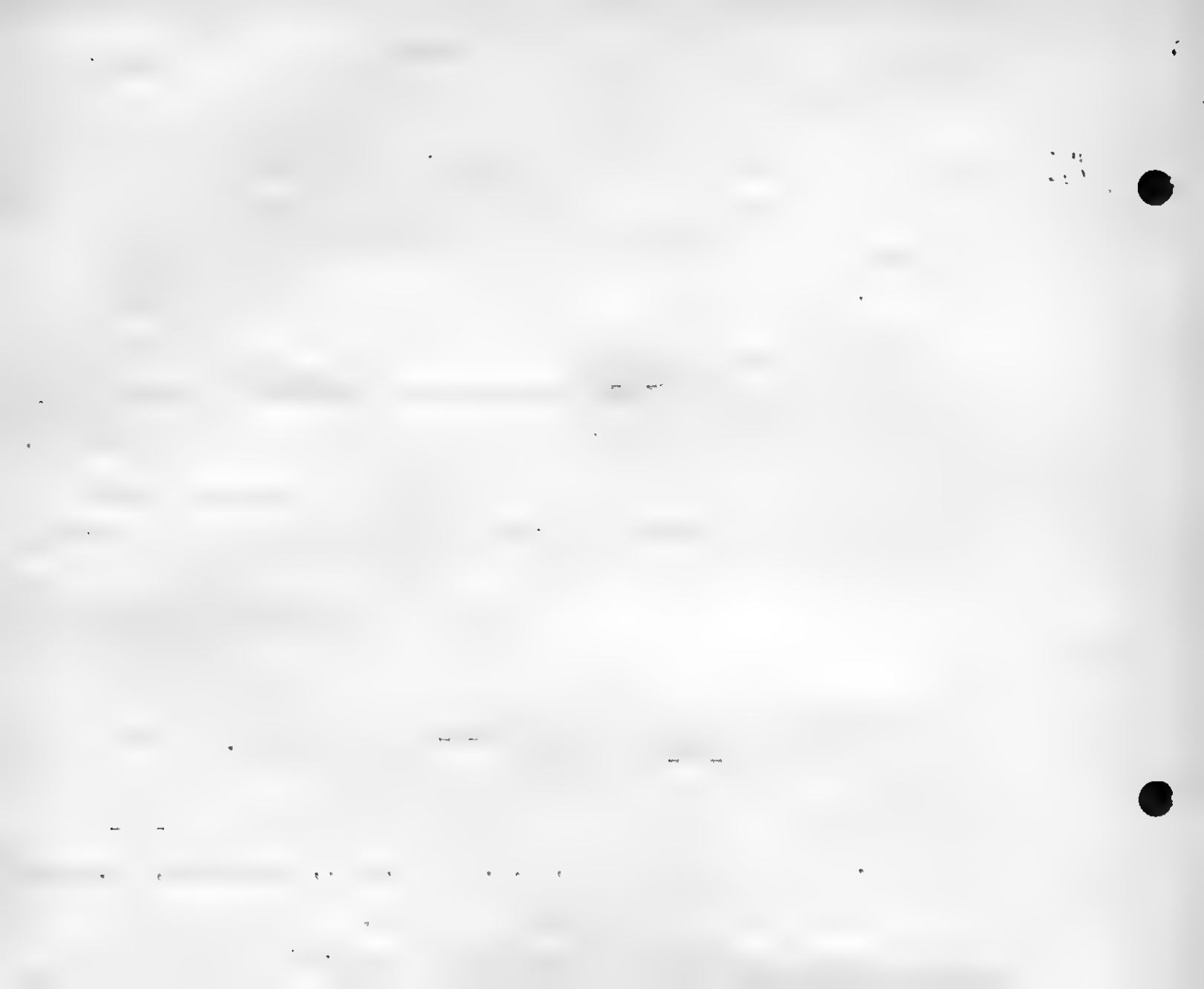
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove these pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | |
|---|--|---|--|--|
| 1 DECEASED NAME
(Type or print) First Middle Last
Bessie Potts | | 2a. DATE OF DEATH
Month Day Year
Jan 28 69 | | 2b. HOUR
720PM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
Jan 4, 1893 | 6. AGE (In years
last birthday)
76 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign
country) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
America | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Allegany Md. | |
| 10. CITY OR TOWN OF DEATH
Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Cumberland Nursing Center | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
Housewife | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before
admission) STATE Md. | 13b. COUNTY
Allegany | 13c. CITY OR TOWN
Cumberland | 3d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
109 Weber Street |
| 14. FATHER'S NAME First Middle Last
Price Shipley | 15. MOTHER'S MAIDEN NAME First Middle Last
Manda Jane Fletcher | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
No | 16b. SOCIAL SECURITY NO
215-34-4856 | 17. INFORMANT
Rhea Smith 217 Frost Ave
Cumberland, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident
4124 DUE TO, OR AS A CONSEQUENCE OF
(b) Multiple Stroke Syndrome
CONDITIONS, IF ANY, WHICH GAVE
RISE TO IMMEDIATE CAUSE (a),
STATE THE UNDERLYING CAUSE
last DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerotic Cardiovascular Disease
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
24 hrs.
years
years | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
NONE | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | 21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-9-56 19, to Jan., 19 69, that (I) (we) saw the deceased alive on 1-28-69 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
G. Overton Himmelwright | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
1-29-69 |
| 22d. PHYSICIAN'S NAME (Type)
G. Overton Himmelwright, M.D. | | 22e. ADDRESS
133 Va. Ave., Cumberland, Md. 21502 | | |
| 23a. BURIAL, CREMATION,
REMOVAL, ETC.
BURIAL | 23b. DATE
JAN 31, 1969 | 23c. NAME OF CEMETERY OR CREMATORY
FAIRVIEW CHRISTIAN CEMET. | 23d. LOCATION (City or Town) (County) (State)
INGLESIDE BEDFORD PENNSYLVANIA | |
| 24. FUNERAL DIRECTOR
Silcox Merritt | | ADDRESS
404 DECATUR ST CUMBERLAND | | 25a. REC'D BY REGISTRAR
DATE FEB 3 1969 |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |



**FOR STATE
HEALTH DEPT.**

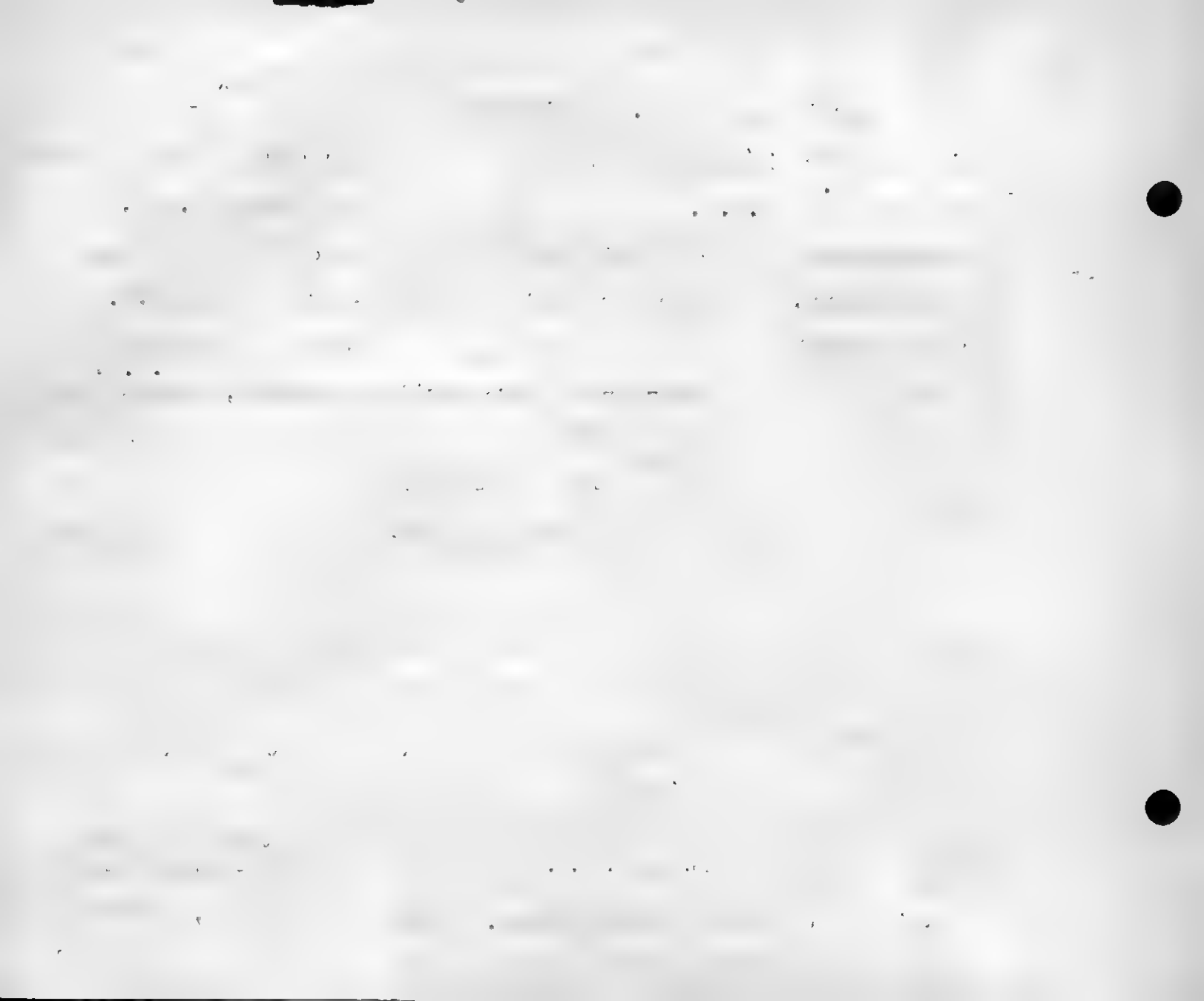
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

| | | | | | | | | | |
|--|--------|---|---|--|----------|---|----------|---|---|
| 1 DECEASED-NAME
(Type or Print) | | | First | Middle | Last | 2a DATE KNOWN
OF EST DEATH MATED <input checked="" type="checkbox"/> 1-22-69 12:30 PM | | | 2b HOUR |
| Myrtle B. Ringler | | | | | | | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years last birthday) | 7 YEARS | 8 MONTHS | 9 DAYS | 10 HOURS | 11 MIN | 2c DATE PRONOUNCED DEAD
Month January 22, Day 1969 Year 1912:30p M |
| F | White | 3/24/1896 | 72 | YRS | | | | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH |
| Pa. | | | U.S.A. | | | | | | Md. |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b KIND OF BUSINESS OR INDUSTRY |
| Cumberland | | | Sacred Heart Hospital | | | Home | | | Home |
| 13a USUAL RESIDENCE (Where deceased lived, if institution on residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d STREET AND NUMBER |
| Penna. | | | Somerset | | | Rural | | | Grantsville, R.D. 1 |
| 14 FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| John Briskey | | | | | | Clara Shumaker | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT | | | ADDRESS |
| No | | | 206-40-8395 | | | Mrs Lucille Wisseman, Grantsville | | | R.D. 1 |
| 18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SHOCK, | | | | | | | | 12 Hours | |
| 5321
(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.) | | | | | | | | 12 Hours | |
| (b) CHEMICAL PERITONITIS | | | | | | | | 12 Hours | |
| (c) PERFORATED DUODENAL ULCER | | | | | | | | 12 Hours | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 21b TIME OF INJURY Month, Day Year
HOUR A.M. P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| 22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
Benedict Skitarelic | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | |
| EXAMINER'S NAME (Type)
BENEDICT SKITARELIC, M.D. | | | | ASS STANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> January 22, 1969 | |
| | | | | ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) | (State) |
| Burial | | 1/25/1969 | | Somerset Co. Memorial | | Somerset, Somerset, Pa | | | |
| 24 FUNERAL DIRECTOR
Stanley M. Thomas Salisbury, Pa | | | | 25a REC'D BY REGISTRAR
JAN 24 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VM 415-10
30M REV. 5-7-68

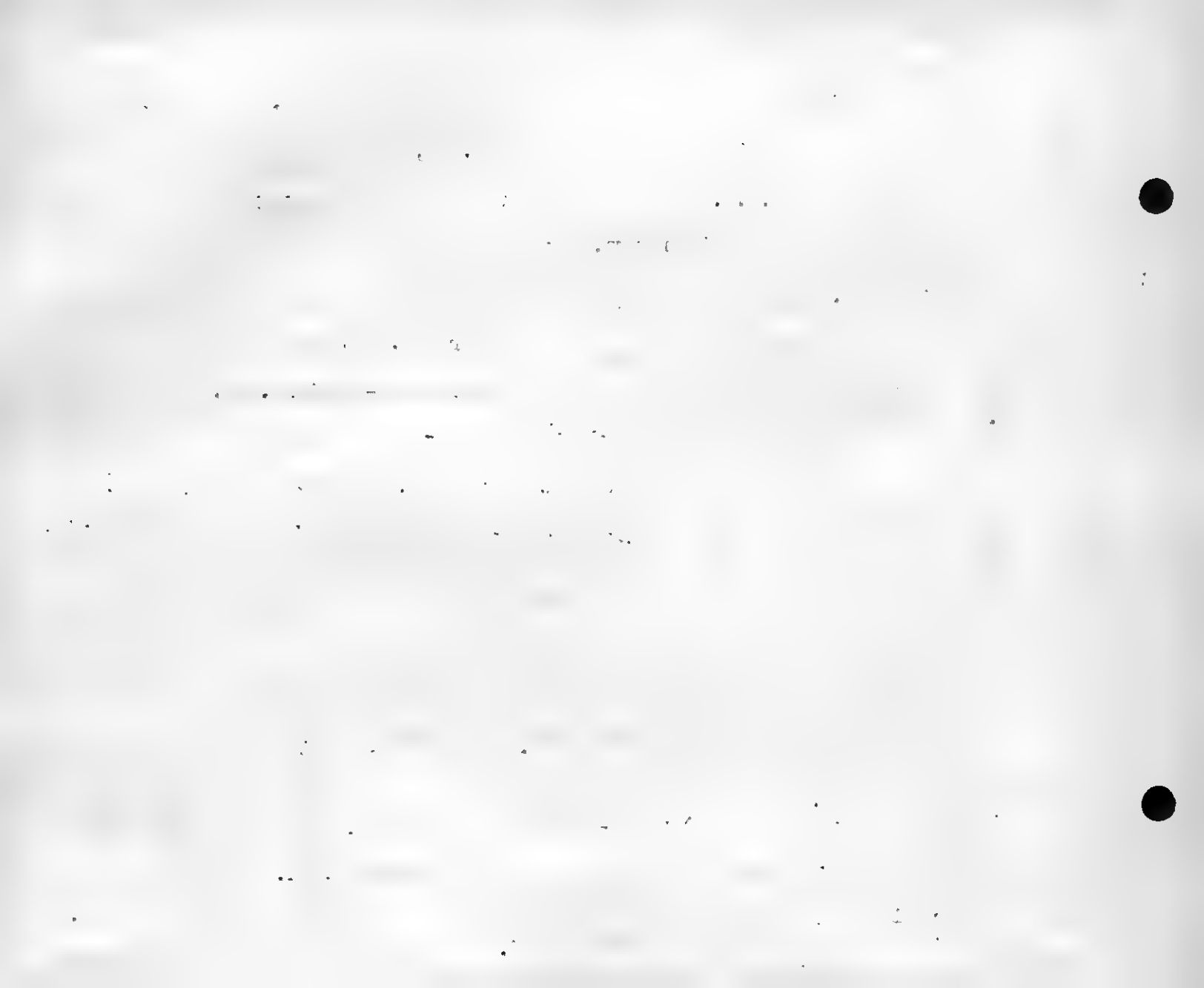
| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|---|---|---|--|---|---|--|----------------------------------|--|-----------------------------|
| 00074 | | 00074 | | | | | | | | | |
| 1 DECEASED NAME (Type or print) Helena Sarah Robertson | | | | | | 2a DATE OF DEATH Jan. 27 1969 | | | 2b HOUR 10A-M | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH Dec. 22, 1879 | | | 6 AGE (In years last birthday) 89 YRS. | | IF UNDER YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a BIRTHPLACE (State or foreign country) Md. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Allegany Md | | | | | |
| 10. CITY OR TOWN OF DEATH Barton | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. | | 13b COUNTY Allegany | | 13c CITY OR TOWN Barton | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | | | |
| 14 FATHER'S NAME First Thomas Middle P Last Lyons | | | | 15. MOTHER'S MAIDEN NAME First Sarah Middle Ann Last Morris | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT Address Althea Lashbaugh-Barton, Md. | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Embolic (coronary or cerebral)
4 +
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Generalized atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 yrs. | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Small gangrenous area at right knee. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from December 3, 1968 , to January 27, 1969 , that (I) (we) last saw the deceased alive on January 22, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE William W. Lesh MD DEGREE MD ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 1-27-69 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) William W. Lesh | | | | | | 22e. ADDRESS Westernport, Md. | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b DATE 1/30/69 | | 23c NAME OF CEMETERY OR CREMATORY Laurel Hill | | 23d LOCATION (City or Town) Moscow Mills (County) Md. (State) | | | | | |
| 24 FUNERAL DIRECTOR E. L. Boral ADDRESS Westernport, Md. | | | | | | 25a REC'D BY REGISTRAR JAN 30 1969 DATE | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--------|--|--|--|--|---|--|
| 1 DECEASED NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | |
| Clara | | | | Ross | Jan. Month 21 Day 1969 Year | | | 2 A.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Female | | White | | Aug. 11, 1892 | | 88 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Allegany Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cumberland | | Kineth Nurs. Home | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution - Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | Allegany | | Barton | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| James Norris | | | | Mary F. Hunucher | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No | | | | Charles Ross-Rawlings, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Fibrosis of Esophagus</u> | | | | | | | | | 6 min |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> | | | | | | | | | 5 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. no. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>68</u> , to <u>Jan 21</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Jan 19</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Clay Durrett</u> | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>1/22/69</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Clay Durrett</u> | | | | 22e. ADDRESS <u>Cumberland, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1/23/69 | | Laurel Hill | | Moscow Mills, Md. | | | |
| 24. FUNERAL DIRECTOR <u>W. S. Boal</u> | | | | ADDRESS <u>Westernport, Md.</u> | | 25a. TRACK BY REGISTRAR <u>JAN 24 1969</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



00076

CERTIFICATE OF DEATH

00076

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(Type or print) Walter Robert Ross | | | 2a. DATE OF DEATH
Month Jan. Day 14 Year 1969 | | | 2b. HOUR
M | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
May 18, 1895 | | 6. AGE (in years last birthday)
73 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Allegany | |
| 10. CITY OR TOWN OF DEATH
Westernport | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Rural | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY
Farm | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md. | | 13b. COUNTY Allegany | | 13c. CITY OR TOWN Westernport | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First William Middle M Last Ross | | 15. MOTHER'S MAIDEN NAME First Mary Middle L. Montgomery Last L. Montgomery | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO
216-05-5757 | | 17. INFORMANT
Mary Ross Westernport, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-renal disease
4121
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 mos
3 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 68 , to Jan , 19 69 , that (I) (we) lost saw the deceased alive on Jan. 14 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
James H. Wolverton, Sr | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1-16-69 | |
| 22d. PHYSICIAN'S NAME (Type)
James H. Wolverton, Sr | | | | 22e. ADDRESS
Piedmont, W.Va | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1/17/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Philos | | 23d. LOCATION (City or Town) (County) (State)
Westernport Md. | |
| 24. FUNERAL DIRECTOR
E. J. Bial | | | | ADDRESS
Westernport, Md. | | 25a. REC'D. BY REGISTRAR
JAN 20 1969 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
James H. Wolverton, Sr | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

0007.

00077

| | | | | | | | | | | | | |
|--|---|--|--|---|---|---|-----------------------|-------------------------------------|----------------|------------------|-----------|--|
| 1 DECEASED-NAME
(Type or print) | | First | Mary | Middle | Margaret | Lost | Rown | 2a DATE OF DEATH | Month | Day | Year | 2b HOUR |
| ROWAN | | | | MARY | | M. | | JANUARY | | 28 | 1969 | 5.00A M |
| 3 SEX | 4. RACE | | 5 DATE OF BIRTH | | 6 AGE (n years
last birthday) | | 7 UNDER 1 YEAR | | 8 UNDER 24 HRS | | | |
| FEMALE | WHITE | | 10-11-22 | | 46 YRS. | | MONTHS | | DAYS | | HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | | | | |
| MARYLAND | USA | | | | ALLEGANY | | | | | | | |
| 10 CITY OR TOWN OF DEATH | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| CUMBERLAND | SACRED HEART HOSPITAL | | HOUSE WIFE | | OWN HOME | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | | | | | |
| MARYLAND | ALLEGANY | | CUMBERLAND | | | | 603 MARYLAND AVENUE | | | | | |
| 14 FATHER'S NAME | First | | Middle | Lost | 15 MOTHER'S MAIDEN NAME | | First | | Middle | Lost | | |
| JANNIE | E. | | LAMP | | (SMITH) | | ELIZABETH | | | | LAMP | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b SOCIAL SECURITY NO | | 17 INFORMANT | | Address | | | | | | |
| NO | | 218-12-5144 | | HOSPITAL RECORD, 900 SETON DRIVE, CUMB., MD. | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <i>Paraplegia due to metastatic disease of spine</i>
DUE TO OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>Carcinoma of pancreas (body) 1 yr.</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 7-30-68 | | Retroperitoneal Mass | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input checked="" type="checkbox"/>
at work at work | | 21e PLACE OF INJURY (AT HOME, HOME, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| <i>A. J. Mirkin M.D.</i> | | | | <input checked="" type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | | 1-28-69 | | |
| 22d PHYSICIAN'S NAME (Type) | | 22e ADDRESS | | | | | | | | | | |
| A. J. MIRKIN, M.D. | | 115 S. CENTRE ST., CUMBERLAND, MD. 2150 | | | | | | | | | | |
| 23a BURIAL, CREMATION
(Specify) | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) | | (State) | | | |
| Buried | Jan. 31, 1969 | | Restlawn Memorial Gardens | | La Vale, Md. | | Allegany | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | | | | |
| SCARPELLI FUNERAL HOME CUMBERLAND, MD. | | | | FEB 4 1969 | | <i>Charles Judge</i> | | | | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
|--|--|---------|-----------------------------|---|-----------------------------------|--|------------------------------------|--|----------------------------|--|------------------|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1 DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a DATE KNOWN
OF EST-
DEATH MATED | | | Month Day Year | | 2b HOUR
A. M. | | |
| ANNA | | | RUPP | | | JAN. 9, 1969 | | | 3:15 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | | 2c. DATE PRONOUNCED DEAD
Month Day Year | |
| FEMALE | | WHITE | | DEC. 1, 1890 | | 78 YRS | | | | | | JAN. 9 1969 3:15 | |
| 7a BIRTHPLACE (State or foreign
country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH | | | | |
| PENNSYLVANIA | | | U.S.A. | | | | | | ALLEGANY Md | | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | | 12a USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | | 12b KIND OF BUSINESS OR
INDUSTRY | |
| CUMBERLAND | | | | DOA SACRED HEART | | | | HOUSEWIFE | | | | OWN HOME | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before
admission) STATE | | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | | | |
| MARYLAND | | | | ALLEGANY | | FROSTBURG | | | | 198 GLENN STREET | | | |
| 14 FATHER'S NAME
First Middle Last | | | | 15 MOTHER'S M A DEN NAME
First Middle Last | | | | | | | | | |
| ISAAC WILLIAMS | | | | MARY ANNI JONES | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO
(If yes give war or dates of service) | | | | 17. INFORMANT
ADDRESS | | | | | |
| | | | | 212-54-8086 | | | | J. CLANCY RUPP, FROSTBURG, MD. 21532 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) CORONARY OCCLUSION | | | | | | | | | | SUDDEN | | | |
| 4107 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Cond trans, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) CORONARY SCLEROSIS | | | | | | | | | | --- | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | | | 20 AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) | | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | | BENEDICT SKITARELIC, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| EXAMINER'S
NAME (Type) | | | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 1-9-69 | | | |
| | | | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | CUMBERLAND, MARYLAND | | | |
| | | | | | | | | ADDRESS (Street, city, town, or county) | | | | | |
| 23a BURIAL, CREMATION
REMOVAL (Specify) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | | | | |
| BURIAL | | | JAN. 11, 1969 | | FPG. MEMORIAL PARK | | | FROSTBURG, MD. | | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS | | | | | | | 25a. RECEIVED BY REGISTRAR
DATE | | 25b. REGISTRAR'S SIGNATURE | | | | |
| JOSEPH R. DURST, FROSTBURG, MD. 21532 | | | | | | | JAN 15 1969 | | [Signature] | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|-------------------------|--|---|--------------------------------|--|--|-------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or print) | | | First
MARTIN | | | Middle
W. | | Last
SCHAEFER | | 2a. DATE OF DEATH
1 Month 26 Day 69 Year | | 2b. HOUR
6:40 AM | | | |
| 3 SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
8-30-88 | | | 6 AGE (In years last birthday)
80 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country)
MD. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
ALLEGANY Md | | | | | | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SACRED HEART HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of last year (if retired))
RETIRED MINER | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
MD. | | | 13b. COUNTY
GARRETT | | | 13c. CITY OR TOWN
GRANTSVILLE | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | | |
| 14 FATHER'S NAME
First
HENRY | | | Middle
SCHAEFER | | | Last
SCHAEFER | | | 15 MOTHER'S MAIDEN NAME
First
(LEINSETTER) CHRISTINEA | | | Middle
SCHAEFER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/> or unknown | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO
215-05-7194 | | | 17 INFORMANT
HOSPITAL RECORDS | | | Address 900 SETON DRIVE CUMBERLAND, MD. | | | |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Massive Pulmonary infarct, bilateral
DUE TO, OR AS A CONSEQUENCE OF
(b) thrombo phlebitis, legs
DUE TO, OR AS A CONSEQUENCE OF
(c) prolonged bed rest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Transurethral resection of prostate | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
1-20-69 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Benign Prostate hypertrophy | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Y | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)
OFFICE BUILDING ETC | | | 21f. LOCATION Street or R.F.D. No | | | City or Town | | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-9- , 19 69 , to 1-26- , 19 69 , that (I) (we) last saw the deceased alive on 1-26- , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Dr. J. L. Valdes | | | DEGREE | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED
1-29-69 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
JOSE L. VALDES, M.D. | | | 22e. ADDRESS
ALGONQUIN HOTEL, CUMB. MD. | | | 22f. ADDRESS
667 E. MAIN ST. PROSBURG, MD. 21502 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
1/28/69 | | | 23c. NAME OF CEMETERY OR CREMATORY
Grantsville Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Grantsville, Garrett Md. | | | | | | |
| 24. FUNERAL DIRECTOR
NEWMAN FUNERAL HOMB, GRANTSVILLE, MD. | | | ADDRESS | | | 25a. FEB 1969 | | | 25b. REGISTRAR'S SIGNATURE
K. Newman | | | | | | |

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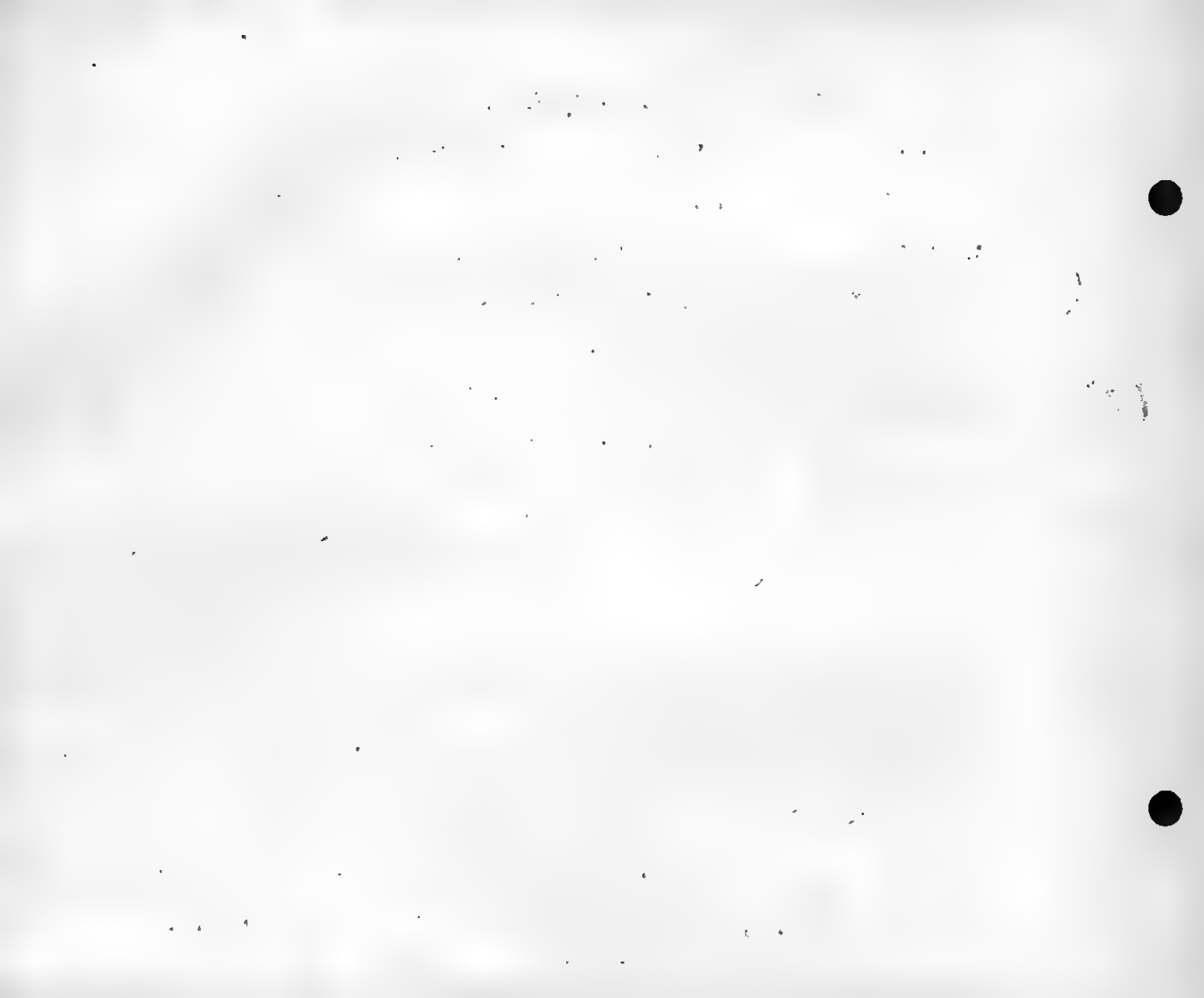
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| LELA | | | REBECCA SCHAUB | | | JANUARY Month 5 Day 1969 Year | | M | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6 AGE (In years lost birthday) | | IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| FEMALE | | WHITE | | JAN. 23, 1902 1903 | | 66 65 YRS | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| GARRETT | | U.S.A. | | | | ALLEGANY Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| FROSTBURG | | | MINERS HOSPITAL | | | HOUSEWIFE | | | | |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | | ALLEGANY | | FROSTBURG | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | ROUTE 1 | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| OTHA | | | GARLITZ | | | ANNABELIE DURST | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT Address | | | | | |
| | | | | | RT. 1, BOX 572 | | | | | |
| | | | MISS ANN SCHAUB, FROSTBURG, MD. | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Ischemia | | | | | | | | 24 hrs. | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic congestive failure | | | | | | | | 2 yrs. | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis | | | | | | | | years | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1964, to Jan 5, 1969, that (I) (we) last saw the deceased alive on Jan 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE L. R. MILES, JR. M.D. | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1-6-69 | | | |
| 22d. PHYSICIAN'S NAME (Type) L. R. MILES, JR. M.D. | | | | | 22e. ADDRESS LONACONING MD, 21539 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| BURIAL | | JAN. 8, 1969 | | F.B.G. MEMORIAL PARK | | FROSTBURG, MD. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| JOSEPH R. DURST, FROSTBURG, MD. 21532 | | | | | JAN 9 1969 | | Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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00081
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH
 00081

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|-----------------------------------|--|
| 1 DECEASED NAME
(Type or print)
(REV.) ALFRED | | First
JESSE | | Middle
SHAV | | Last
SHAV | | 2a. DATE OF DEATH
Month 01 Day 05 Year 69 | | 2b. HOUR
12:30 M | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH
05-01-11 | | 6 AGE (In years last birthday)
57 YRS. | | IF UNDER YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country)
WEST VIRGINIA | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
ALLEGANY COUNTY, Md | | | | | |
| 10 CITY OR TOWN OF DEATH
CUMBERLAND | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SACRED HEART HOSPITAL | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
REVEREND | | 12b. KIND OF BUSINESS OR INDUSTRY
CHURCH | | | | | |
| 13a U.S.A. RESIDENCE (Where deceased lived 1 year or more before death)
STATE WEST VIRGINIA COUNTY MINERAL | | 13c CITY OR TOWN
WILEY FORD | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER
Along River Avenue | | | | | |
| 14 FATHER'S NAME
First SIMON Middle J. Last SHAV | | 15 MOTHER'S MAIDEN NAME
First (HOTTINGER) MARY Middle C. Last SHAV | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown NO (If yes give war or dates of service) | | 16b SOCIAL SECURITY NO
236-14-2951 | | 17 INFORMANT
Address MD. 21502
SACRED HEART HOSPITAL, 900 SETON DR., JUMB., | | | | | | | |
| 18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardio Pulmonary failure
1517
DUE TO, OR AS A CONSEQUENCE OF
CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Carcinoma of stomach
DUE TO, OR AS A CONSEQUENCE OF
(c) Carcinomatous
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days
2 mos. | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/10, 1968 to 12/31, 1969 , that (I) (we) last saw the deceased alive on 11/4, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE
J.A. PAGAN, M.D. | | DEGREE
M.D. | | ATTENDING PHYS.
<input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/7/69 | |
| 22d. PHYSICIAN'S NAME (Type)
J.A. PAGAN, M.D. | | 22e. ADDRESS
1068 NATIONAL HWY., LA AVLE, MD. 21502 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL, OR DISPOSAL
Removal, Burial | | 23b. DATE
1/7/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Franklin, Pendleton, W. Va. | | | | | |
| 24. FUNERAL DIRECTOR
Wayne George | | ADDRESS
Cumberland, Md. | | 25a. REC'D BY REGISTRAR
JAN 9 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

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YT : Y V JJ

1. The first part of the document is a list of names and titles, including "J. T. ...", "T. ...", and "I. ...".

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1. 2.

17 0000 1771 1771 1771

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

31

112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 1044 1045 1046 1047 1048 1049 1050 1051 1052 1053 1054 1055 1056 1057 1058 1059 1060 1061 1062 1063 1064 1065 1066 1067 1068 1069 1070 1071 1072 1073 1074 1075 1076 1077 1078 1079 1080 1081 1082 1083 1084 1085 1086 1087 1088 1089 1090 1091 1092 1093 1094 1095 1096 1097 1098 1099 1100 1101 1102 1103 1104 1105 1106 1107 11

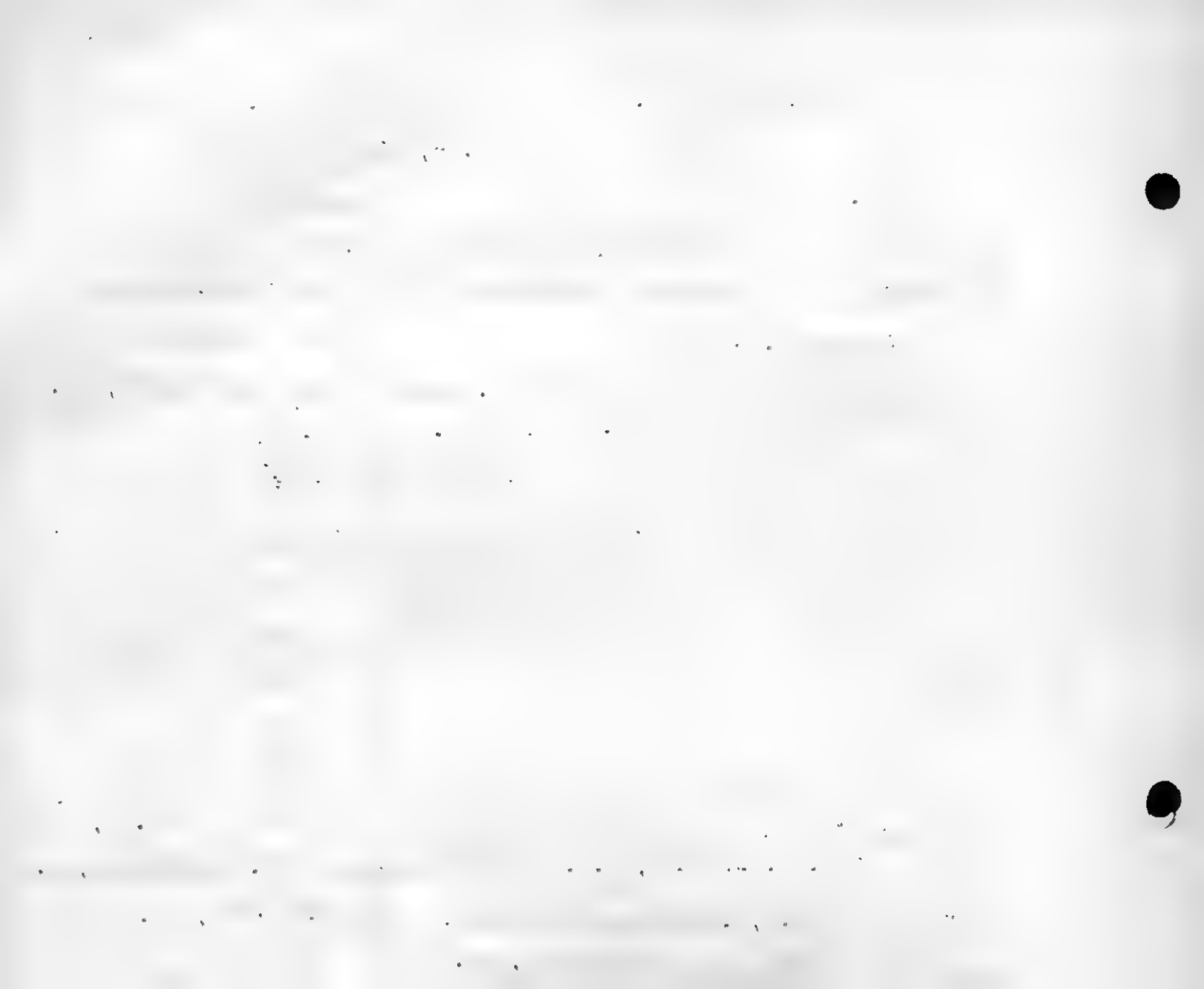
15.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|-----------------------|--|
| 00082 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1 DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a DATE OF DEATH
Month Day Year | | 2b HOUR | | |
| CHARLES | | | E. SHAW | | | JAN. 2 1968 | | 2 P M | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years
last birthday) | | IF UNDER 24 HRS
MONTHS DAYS HOURS M.N. | | |
| MALE | | WHITE | | JAN. 26, 1884 | | 84 YRS. | | | | |
| 7a BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | |
| PENNA. | | USA | | | | ALLEGANY | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a USUAL OCCUPATION (Kind of work done
during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| CUMBERLAND | | | 645 BEDFORD STREET | | | TELLER | | BANKING | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution
admission) STATE | | | 13b. COUNTY | | 13c CITY OR TOWN | | 3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | |
| MARYLAND | | | ALLEGANY | | CUMBERLAND | | | | 645 BEDFORD STREET | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| CHARLES E. SHAW | | | MARY HEBENER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT Address | | | | | |
| NO | | | 217 14 4126 | | MRS. NAURENE SHAW CUMBERLAND, MD. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <i>Atherosclerotic Cardio-Vase Disease</i>
4123
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>myocarditis & Decompensation</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Coronary Heart Disease</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 yr
4 mo.
1 yr | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f LOCATION Street or RFD No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct. 15, 1968, to Jan. 2, 1969, that (I) (we) last saw the deceased alive on Jan. 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Clay E. Durrett</i> | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c DATE SIGNED
JAN. 3, 1968 | | | |
| 22d PHYSICIAN'S NAME (Type)
CLAY E. DURRETT, M.D. | | | | | 22e ADDRESS
236 VIRGINIA AVE. CUMBERLAND, MD. | | | | | |
| 23a BURIAL, CREMATION,
REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | | |
| BURIAL | | JAN. 5, 1968 | | HILLCREST BURIAL PARK | | CUMBERLAND, MD. | | | | |
| 24. FUNERAL DIRECTOR
BYRON KIGHT
CUMBERLAND, MD. | | | | | 25a REG. BY REGISTRAR
JAN 6 1969 | | 25b REGISTRAR'S SIGNATURE
<i>John Judge</i> | | | |

WR 4-15-68
304 REV 1-68



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

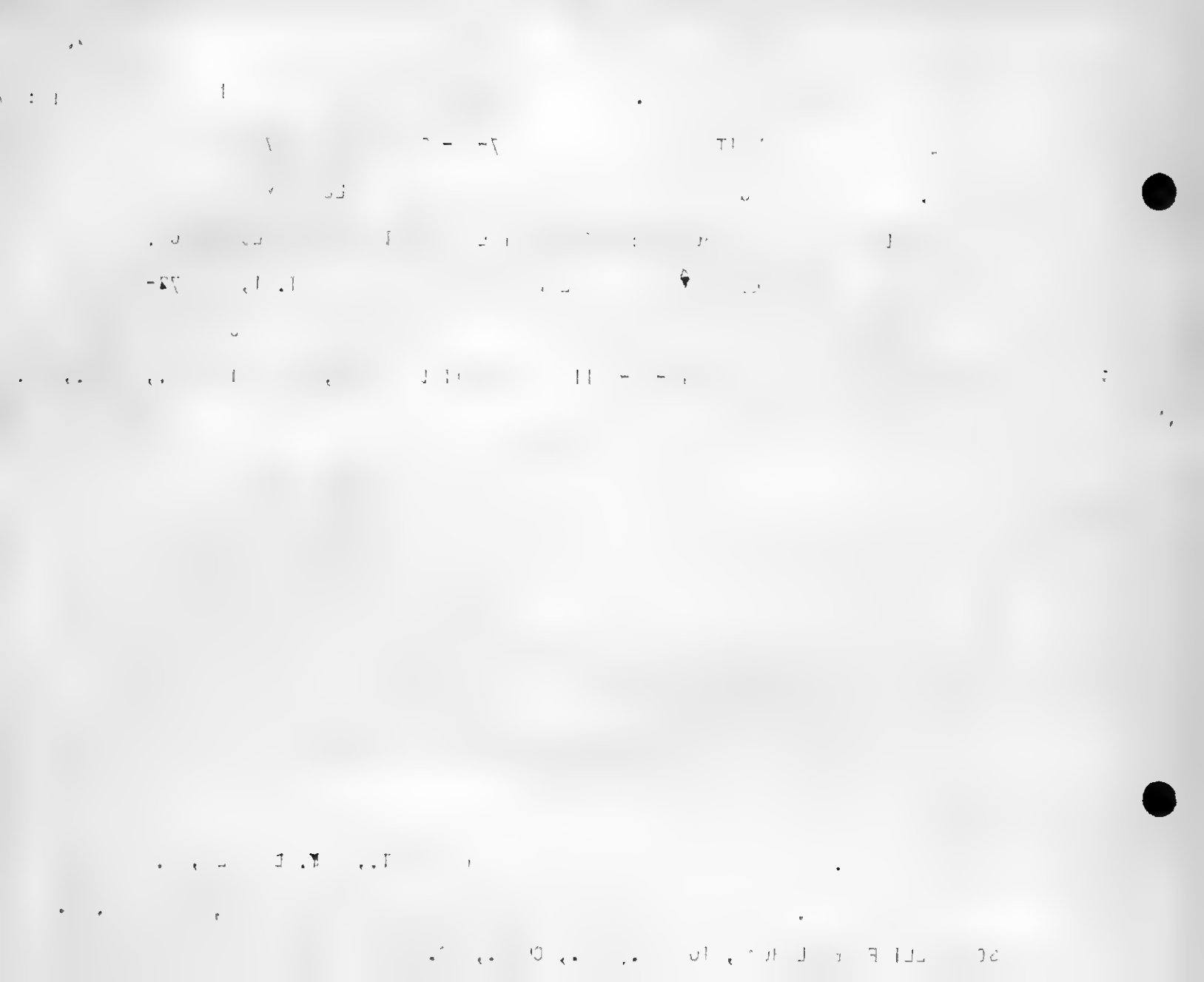
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VR 45M 69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|-----------------|--|----------------------------|--|--|---|--|---|--------------|--------------|--|
| 1 DECEASED-NAME
(Type or print) | | First
GEORGE | Middle
E. | Last
SHOEMAKER | 2a. DATE OF DEATH
Month 1 Day 3 Year 69 | | 2b. HOUR
10:25 PM | | | | |
| 3 SEX
MALE | 4 RACE
WHITE | | 5 DATE OF BIRTH
7-20-92 | | 6 AGE (In years
last birthday)
72 76 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | | |
| 7a. BIRTHPLACE (State or foreign country)
PENNA. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
ALLEGANY Md | | | | | |
| 10 CITY OR TOWN OF DEATH
CUMBERLAND | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SACRED HEART HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done)
Retired Carpenter-
RETIRED FROM LUMBER CO. | | 12b. KIND OF BUSINESS OR INDUSTRY
Lumber | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
MARYLAND | | 13b. CITY OR TOWN
ALLEGANY | | 13c. CITY OR TOWN
OLDTOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
RT. 1, BOX 72-A | | | |
| 14 FATHER'S NAME
First
GEORGE | | Middle
SHOEMAKER | | Last
Last | | 15 MOTHER'S MAIDEN NAME
First
ANNA | | Middle
JANE | | Last
BAER | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no (Unknown) (If yes give war or dates of service)
NO | | 16b. SOCIAL SECURITY NO.
214-05-5611 | | 17. INFORMANT
HOSPITAL RECORD, 900 SETON DR., CUMB., MD. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Chronic Lymphocytic Leukemia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
6 mos. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION
Street or R.F.D. No | | City or Town | | County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug.</u> , 1968, to <u>1/3</u> , 1969, that (I) (we) last saw the deceased alive on <u>1/3</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u>
M.D. DEGREE
ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | 22c. DATE SIGNED
<u>1/3/69</u> | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
DR. PAGAN | | | | | 22e. ADDRESS
1068 N.W., HWT. LA VALE, MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
Jan. 6, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Davis Memorial Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Allegany, Md. | | | | | |
| 24. FUNERAL DIRECTOR
SCARPELLI FUNERAL HOME, 108 VA. AVE., CUMB., MD. | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 9 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--------|--|--------------------------------|--|--|--|-----------------------------------|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| Grace Marie Shroyer | | | | | | MATED <input checked="" type="checkbox"/> 1-11-69 19 9 P M | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years last birthday) | IF UNDER 1 YEAR | 5 UNDER 24 HRS | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | White | 3 Oct. 27, 1919 59 YRS | | MONTHS DAYS | HOURS MIN | January 12, 1969 4:00p M | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| Pennsylvania | | USA | | | | Allegheny | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Ellerslie | | | | | 12b. 3152 Main St | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | | | |
| Maryland | | | Allegheny | Ellerslie | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| Edward Robb | | | Emma Corley | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT ADDRESS | | | | |
| No | | | 011-22-6756 | | Mrs. June Folk, Cumberland, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION | | | | | | | | SUDDEN | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF CORONARY SCLEROSIS | | | | | | | | -- | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | HOUR A.M. P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <i>Benedict Skitarellic</i> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | January 12, 1969 | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) CUMBERLAND, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | Jan. 15, 1968 | | Corns Cemetery | | Hyndman, Somerset, Pa. Rd 1 | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Harvey H. Zeigler, Hyndman, Pa. | | | | JAN 17 1969 | | <i>Charles Judge</i> | | | |

CERTIFICATE OF DEATH

00085

00085

| | | | | | | | |
|---|--|---|---------------------|--|---|--|----------------------|
| 1 DECEASED-NAME
(Type or print) | | First
MARY | Middle
ELIZABETH | Last
SIEFERS | 2a. DATE OF DEATH
Month Day Year
JANUARY 29, 1969 | | 2b. TIME
10:20 AM |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
11-20-92 | | 6. AGE (In years
last birthday)
76 YRS | |
| 7a BIRTHPLACE (State or foreign country)
MARYLAND | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
ALLEGANY Md | |
| 10 CITY OR TOWN OF DEATH
CUMBERLAND | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SACRED HEART HOSPITAL
900 SETON DRIVE CUMB. MD | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a USUA. RESIDENCE (Where deceased lived, if institution, residence before admission) STATE
MARYLAND | | 13b COUNTY
ALLEGANY | | 13c CITY OR TOWN
CUMBERLAND | | 13d STREET AND NUMBER
520 CUMBERLAND STREET | |
| 14. FATHER'S NAME
First Middle Last
WILLIAM GRABENSTEIN | | 15. MOTHER'S M.A.DEN. NAME
First Middle Last
ANNA GRABENSTEIN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
NO | | 16b SOCIAL SECURITY NO.
(If yes give war or dates of service)
212-12-8771 | | 17 INFORMANT
Address
SACRED HEART HOSP - 900 SETON DRIVE CUMBERLAND, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | |
| PART 1 DEATH WAS CAUSED BY. | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Cardiac decompensation</i> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic Ca of endometrium</i> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Arteriosclerotic Ht. Disease</i> | | | | | | | |
| 19a DATE OF OPERATION
<i>2 yrs ago</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Vag. Bleeding - Dr.C.</i> | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-10</i> , 1969, to <i>1-29</i> , 1969, that (I) (we) last saw the deceased alive on <i>1-29</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Dr. J. J. Mirkin</i> | | DEGREE
ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
<i>1-30-69</i> | | | |
| 22d. PHYSICIAN'S NAME (Type)
DR. A. J. MIRKIN | | 22e. ADDRESS
115 S. CENTRE ST., CUMBERLAND, MD. | | | | | |
| 23a BURIAL, CREMATION, OR REMOVAL (Specify) | | 23b DATE
<i>2/11/69</i> | | 23c NAME OF CEMETERY OR CREMATORY
<i>SS. Peter + Paul Con.</i> | | 23d LOCATION (City or Town) (County) (State)
<i>Cumb. Wilkeson Md</i> | |
| 24. FUNERAL DIRECTOR
<i>Louis Stein Inc. Cumb. Md.</i> | | ADDRESS | | 25a REC'D BY REGISTRAR
DATE
<i>FEB 3 1969</i> | | 25b REGISTRAR'S SIGNATURE
<i>Richard Judge</i> | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--------|--|--|--|--|--|--|---|--------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| Harvey William Simons | | | | | | Month Day Year | | 1-21-69 198:00p M | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (n years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | White | 3/11/1887 | 81 YRS. | | | Month Day Year | | January 21, 1969 19 8:30p M | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Penna | | U.S.A. | | | | Allegany Md | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cumberland Rt #3 | | | | | | Retired Employee- P. E. Co | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER | | |
| Maryland | | | Allegany | | Cumberland | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Webster Simons | | | Mary Rice | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | ADDRESS | | |
| No | | | 214-10-5341 | | Mrs. Lillian Simons | | Rt 3- Bedford Road
Cumberland, Maryland | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | STUTTEN | |
| IMMEDIATE CAUSE (a) 4109 | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| CORONARY OCCLUSION | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| (b) | | | | | | | | | |
| CORONARY SCLEROSIS | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month Day Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| | | | HOUR A.M. P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State |
| | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> JANUARY 21, 1969 | | | |
| BENEDICT SKITARELIC, M.D. | | | ADDRESS (Street, city, town, or county) | | | CUMBERLAND, MARYLAND | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1/24/69 | | Hillcrest Burial Park | | Cumberland Allegany Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Silcox-Merritt Funeral Service | | | | Cumberland, Md | | JAN 23 1969 | | [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(Type or print) ALBERT | | First C. Middle C. Last STURTZ | | 2a. DATE OF DEATH
Month JAN. Day 17 Year 1969 | | 2b. HOUR 4:00 AM A PM M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
07-31-85 1895 | | 6. AGE (In years last birthday)
73 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
PENNA. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
ALLEGANY | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SACRED HEART HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
KELLY TIRE CO. | | 12b. KIND OF BUSINESS OR INDUSTRY
MFG. TIRES | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE
PENNA. | | 13b. CITY OR TOWN
WELLERSBURG | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
BOX 3, WELLERSBURG, PENNA. 15564 | |
| 14. FATHER'S NAME First JOSEPH Middle STURTZ Last STURTZ | | 15. MOTHER'S MAIDEN NAME First LILLIE Middle GARY Last GARY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO | | 16b. SOCIAL SECURITY NO
247-10-6617 | | 17. INFORMANT Address
HOSPITAL CHART SACRED HEART HOSPITAL CUMBERLAND, MD. 21502 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) 3 yrs -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Longtime heart disease following bout of flu & pneumonia | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March, 1966 , to 1/17, 1969 , that (I) (we) last saw the deceased alive on 1/16 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (and did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
J.A. PAGAN, M.D. | | DEGREE
M.D. | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
1/18/69 | |
| 22d. PHYSICIAN'S NAME (Type)
J.A. PAGAN, M.D. | | 22e. ADDRESS
1068 NATL HWY LA VALE, CUMB., MD. | | | | | |
| 23a. BURIAL CREMATION REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 19, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Wellersburg Cemetery Wellersburg, Somerset, Pa. | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR
ZIEGLER FUNERAL HOME | | ADDRESS
HYNDMAN, PENNA. | | 25a. REC'D BY REGISTRAR
JAN 23 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

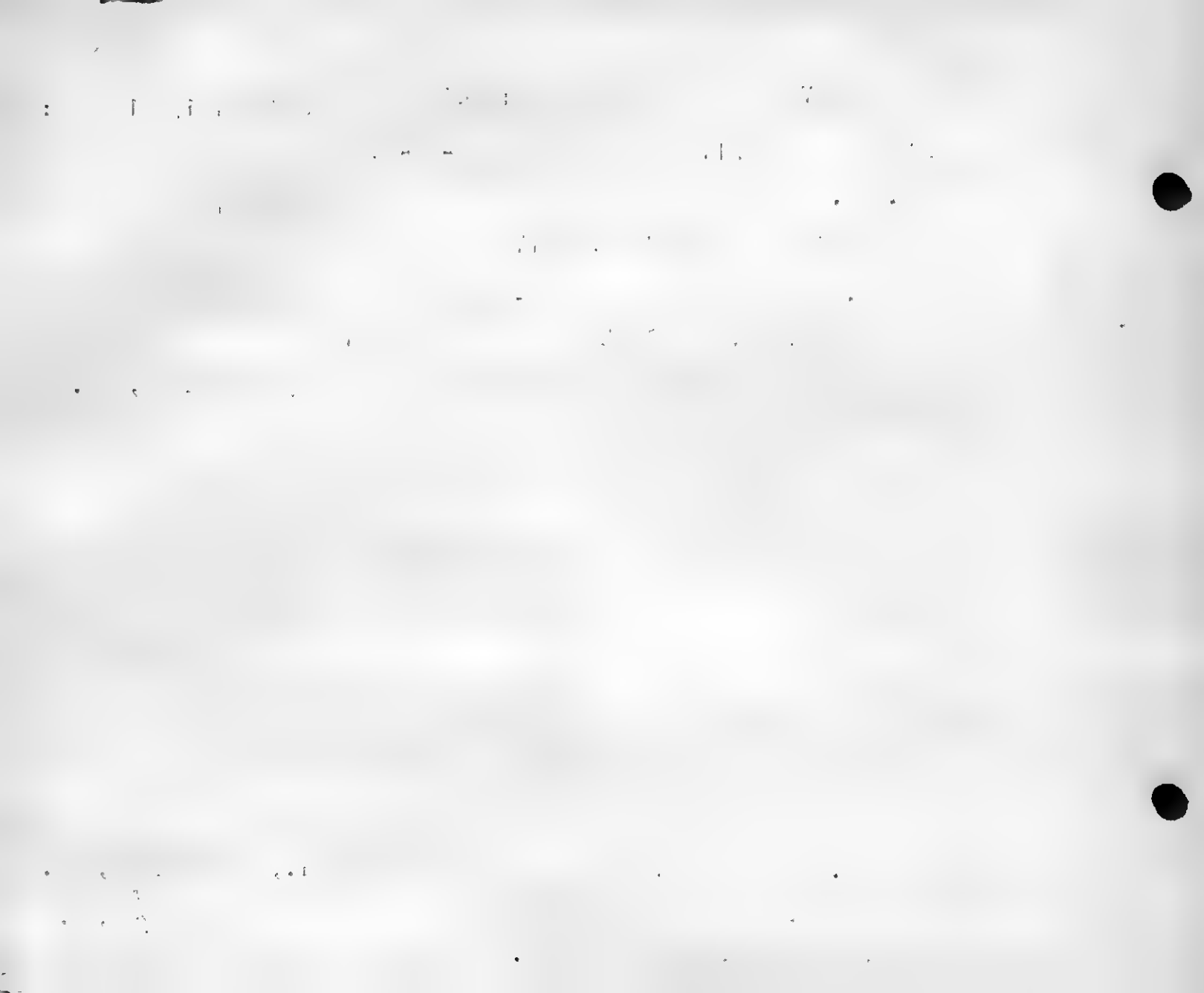
MEDICAL CERTIFICATION

$\sqrt{1 - \frac{v^2}{c^2}}$

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert in the carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

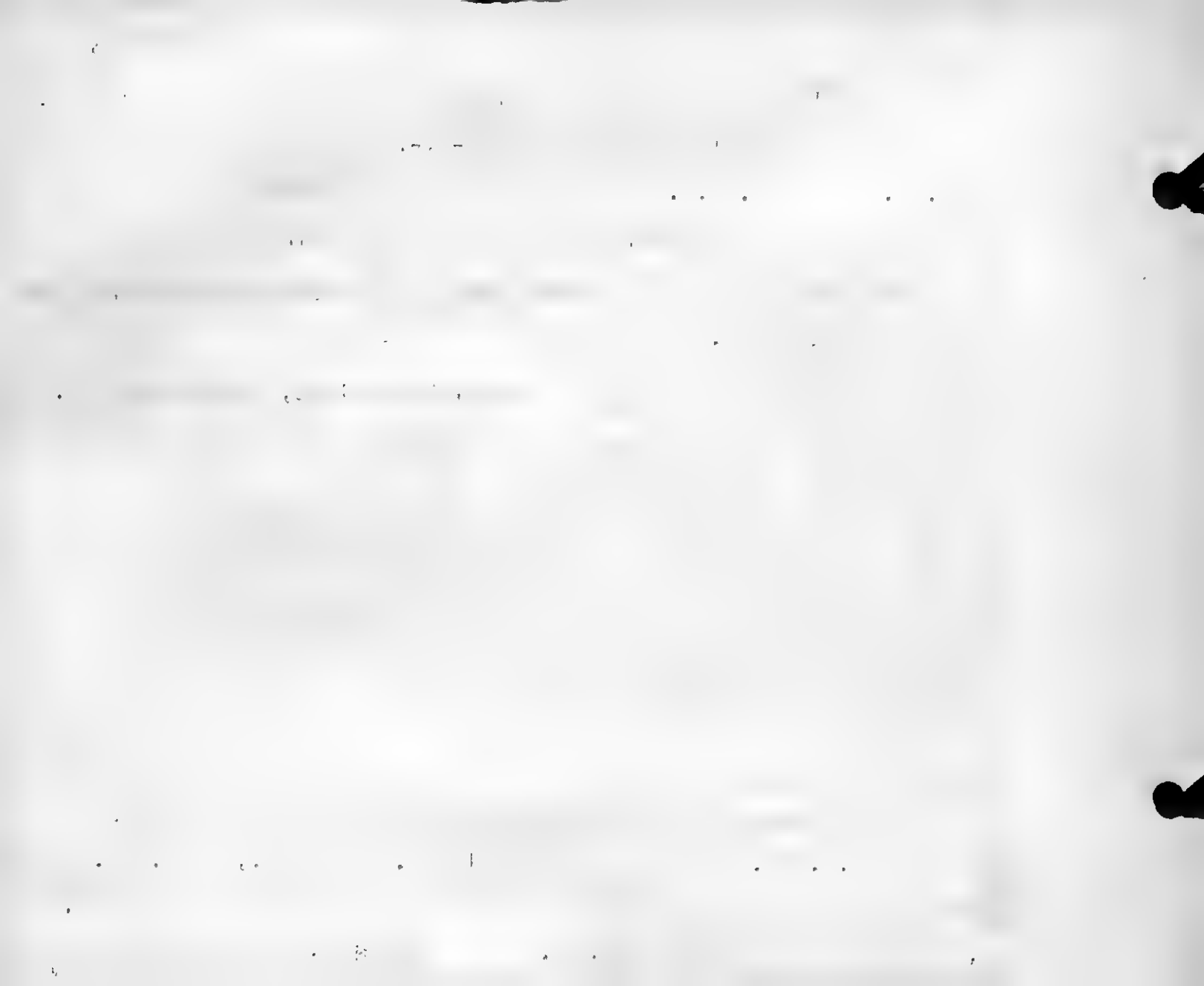
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
|---|--|--|--|--|---|---|--|---|---|---|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
ROY | | Middle
T | | Last
TABLER | | 2a. DATE OF DEATH
Month Day Year
JANUARY 17 1969 | | 2b. HOUR
7:50 PM | | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
3-20-92 | | | 6. AGE (In years last birthday)
78 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS
11 11 | | |
| 7a. BIRTHPLACE (State or foreign country)
CUMB. MD. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
ALLEGANY Md | | | | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
MEMORIAL HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if instituton Residence before admission) STATE
MD. | | | 13b. COUNTY
ALLEGANY | | | 13c. CITY OR TOWN
CUMBERLAND | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
622 OLDTOWN ROAD | | |
| 14. FATHER'S NAME
First Middle Last
AUGUSTA M. TABLER | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
SAVILLA GLOVER | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
no | | | 16b. SOCIAL SECURITY NO
(If yes give war or dates of service)
705-05-8030 | | | 17. INFORMANT
Address
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | | | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c))
PART DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <i>myocardial infarction</i>
DUE TO, OR AS A CONSEQUENCE OF-
(b) <i>arteriosclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF-
(c) <i>hypertension</i>
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>24 hrs</i> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| 21d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | | 21f. LOCATION Street or R.F.D. No City or Town County State
43 GREENE ST., CUMBERLAND, MD. | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 17, 1969</i> to <i>Jan 22, 1969</i> , that (I) (we) last saw the deceased alive on <i>Jan 17, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Dr. Blane Schindler</i> | | | | | | DEGREE
ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
<i>1/22/69</i> | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
DR. BLANE SCHINDLER | | | | | | 22e. ADDRESS
43 GREENE ST., CUMBERLAND, MD. | | | | | | | |
| 23a. BURIAL, CREMATION, or other disposal
Burial | | | 23b. DATE
Jan. 20, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Park | | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Allegany, Md. | | | | | |
| 24. FUNERAL DIRECTOR
James F. Scarpelli, Cumberland, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE
JAN 21 1969 | | 25b. REGISTRAR'S SIGNATURE
<i>James F. Scarpelli</i> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
|---|--|-----------------------------|-------|---|--------|-----------------------------------|------|--|--|--|---------------|----------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or print) | | | First | | Middle | | Last | | 2a DATE OF DEATH | | PM
2b HOUR | | |
| BESSIE | | | E. | | TAYLOR | | | | JANUARY 23 1969 | | 9:25 | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | | 6 AGE (In years last birthday) | | 7 UNDER 1 YEAR | | 8 UNDER 24 HRS | |
| FEMALE | | WHITE | | 5-31-1897 | | | | 71 YRS | | MONTHS | | DAYS | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. COUNTY OF DEATH | | | | | |
| W. VA. | | U. S. A. | | WIDOWED | | DIVORCED | | ALLEGANY | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address) | | | | 12a USUAL OCCUPATION (Kind of work done during life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| CUMBERLAND | | | | MEMORIAL HOSPITAL | | | | HOUSEWIFE | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | | | 13b CITY OR TOWN | | | | 13c INSIDE CITY LIMITS? | | 13d STREET AND NUMBER | | 13e | |
| MARYLAND | | | | ALLEGANY CUMBERLAND | | | | YES X NO | | CUMBERLAND | | NURSING HOME | |
| 14 FATHER'S NAME | | | | First | | Middle | | Last | | 15 MOTHER'S MAIDEN NAME | | | |
| GEORGE | | | | E. | | CLARK | | | | ELLEN WILSON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b SOCIAL SECURITY NO | | | | 17 INFORMANT | | | | Address | |
| Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | | | | | | MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myocardial Infarction</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Atherosclerosis</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Atherosclerosis</u> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING | | | | 21b TIME OF INJURY | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. cert. examiner) | | | | HOUR A.M. Month Day Year | | | | | | | | | |
| 21d INJURY OCCURRED | | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | Cumberland Allegany | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/17/69</u> , 19 <u>69</u> , to <u>1/23/69</u> , 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>1/23/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death | | | | | | | | | | | | | |
| 22b SIGNATURE | | | | 22c DATE SIGNED | | | | 22d PHYSICIAN'S NAME (Type) | | | | | |
| <u>R. J. WMS.</u> | | | | 1/25/69 | | | | 122 S. CENTREST., CUMB. MD. | | | | | |
| 23a BURIAL (CREMATION, etc.) | | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | | 1/27/69 | | Philos | | | Westernport Md. | | | | |
| 24 FUNERAL DIRECTOR | | | | 25a REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| E. S. Boat | | | | Westernport, Md. | | | | JAN 30 1969 | | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|---|--------|--|---|--|--------|--|------|--|-----------------------------------|--|----------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or Print) | | | First | | Middle | | Last | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| Charles Thompson | | | | | | | | | Month Day Year
1-8-69 19 | | 3 A M | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | |
| Male | White | April 14, 1894 | 74 YRS | MONTHS | DAYS | HOURS | MIN | Month Year
1-8-69 19 | | 3 A M | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | | | |
| Maryland | | U S A | | | | Allegany Md. | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Cumberland | | | Memorial Hospital | | | Retired Laborer | | | B & O R R | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | | Allegany | | Cumberland | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Route 2, Valley Road | | |
| 14 FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | |
| Edward Thompson | | | | | | | | | Mary Eli Thomas | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17 INFORMANT | | | | | | |
| No | | | --- | | | Memorial Hospital | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | | | | | | HOURS | | |
| 4107 CORONARY OCCLUSION | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | |
| (b) CORONARY SCLEROSIS | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| | | | HOUR A.M. P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or town County State | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | | | | |
| Benedict Skitarelic | | | M.D. | | | January 8, 1969 | | | | | | |
| EXAMINER'S NAME (Type) | | | BENEDICT SKITARELIC, M.D. | | | DEPUTY MEDICAL EXAMINER | | | | | | |
| | | | | | | ADDRESS (Street, city, town, or county) | | | | | | |
| | | | | | | CUMBERLAND, MARYLAND | | | | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| Burial | | Jan. 10, 1969 | | Allegany County Cemetery | | Cumberland Alleg Md. | | | | | | |
| 24 FUNERAL DIRECTOR | | ADDRESS | | Md. | | 25a. REC'D BY REG. STRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| John J. Hafer, Jr. | | 230 Balto Ave. Cumberland | | | | JAN 10 1969 | | | | | | |

FOR STATE HEALTH DEPT.

00091

00091

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

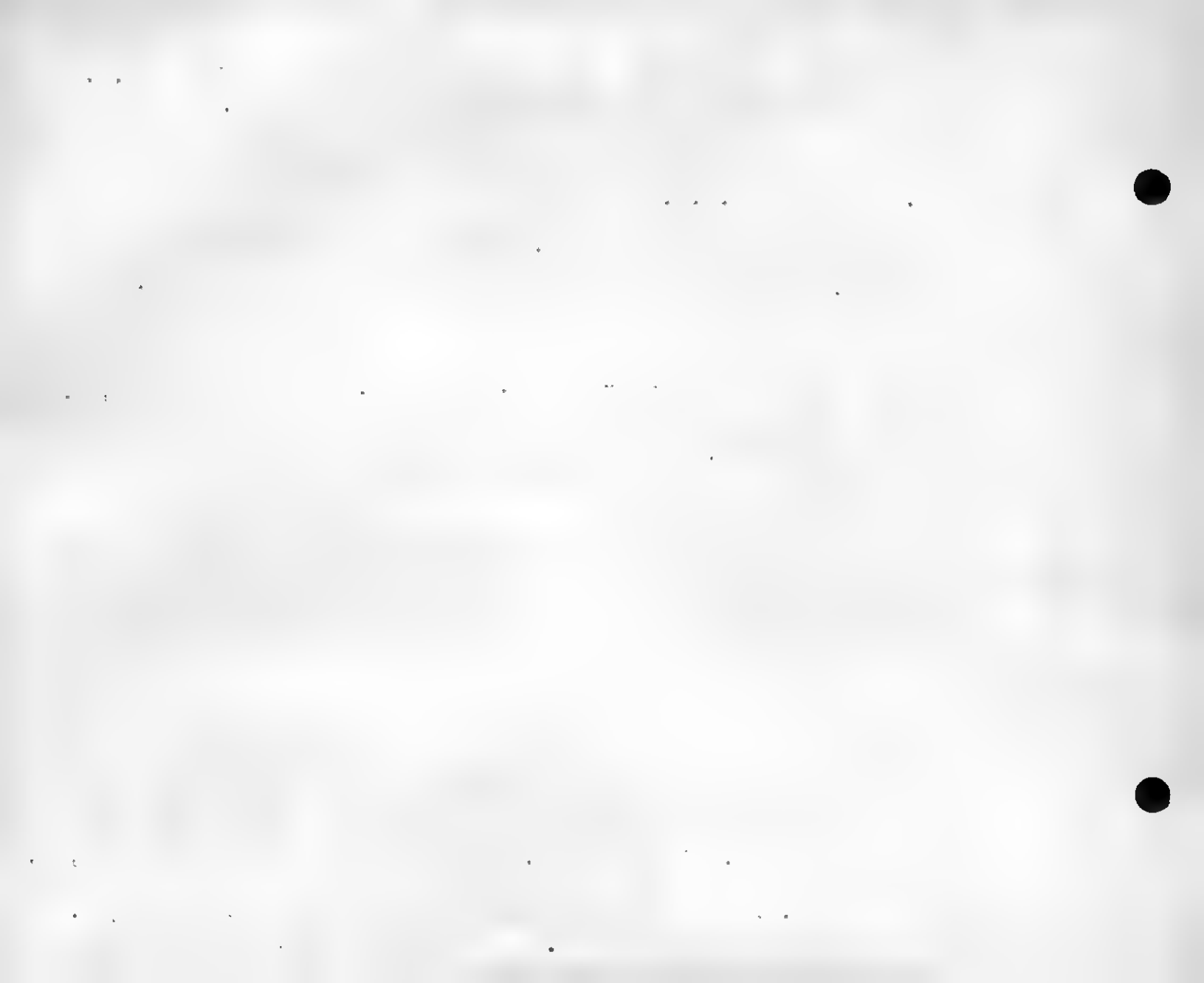
| | | | | | | | | | |
|---|--------|--|--|--|--|--|---|---|--|
| 1 DECEASED NAME
(Type or Print) | | | First | Middle | Last | 2a. DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> 1-18-69 17:50a M | | | 2b. HOUR |
| Elise Taliaferro Towler | | | | | | | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (in years last birthday) | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year 1-18-69 19 7:50a M | |
| Female | White | June 22, 1908 | 60 YRS. | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Allegany Md | | | |
| Maryland | | USA | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Cumberland | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)
Memorial Hospital-DOA | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Owner & Operator | | | 12b. KIND OF BUSINESS OR INDUSTRY
Hotel Inn |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
Maryland | | | 13b. COUNTY
Allegany | | 13c. CITY OR TOWN
Cumberland | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
229 Baltimore Avenue | |
| 14. FATHER'S NAME
Ernest Hunter Taliaferro | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME
Ella Hartley Cave | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Lindsay C. Taliaferro, Sr., Pheonix, Maryland | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 CORONARY OCCLUSION SUDDEN
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY SCLEROSIS
(c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F. No | | City or Town | | County | State |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
Benedict Skitarelic | | EXAMINER'S NAME (Type)
BENEDICT SKITARELIC, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER XX | |
| | | | | | | 22b. DATE SIGNED
January 18, 1969 | | ADDRESS (Street, city, town, or county)
Cumberland, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1/21/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | 23d. LOCATION (City or Town)
Cumberland, Allegany, Md. | | 23e. LOCATION (County) (State) | |
| 24. FUNERAL DIRECTOR
Charles E. Hafer | | ADDRESS
Charles E. Hafer, 230 Balto. Ave., Cumberland, Md. | | 25a. REC'D BY REGISTRAR
JAN 21 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corob' papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|---|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) Hattie | | | First Mae Middle Valentine Last | | | 2a. DATE OF DEATH 12:50 P.M. | | 2b. HOUR 12:50 | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
3/1/1886 | | 6. AGE (In years last birthday)
82 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (State or foreign country)
Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Allegany | | Md | |
| 10. CITY OR TOWN OF DEATH
Cumberland | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Allegany Co. Infirmary | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institut on admission) STATE
Md. | | 13b. CITY OR TOWN
Allegany | | 13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER
Unk. | | | |
| 14. FATHER'S NAME First Samuel Middle I Last Hughes | | | 15. MOTHER'S MAIDEN NAME First Mary Middle Jane Last ??? | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO
220-10-2442 | | 17. INFORMANT Address
Mr. Gilbert T. Garlitz, Cumberland, Md. Son | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) Gen. Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased, from Sept 5 , 19 68 , to Jan 6 , 19 69 , that (I) (we) lost the deceased alive on Jan 4 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
George M. Simons, M. D. | | | | 22c. DATE SIGNED
1/7/1969 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
George M. Simons, M. D. | | | | 22e. ADDRESS
Memorial Hospital, Cumberland, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 9, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Allegany, Md. | | | |
| 24. FUNERAL DIRECTOR
James F. Scarpelli, Cumberland, Md. | | | | 25a. REC'D BY REGISTRAR
JAN 10 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

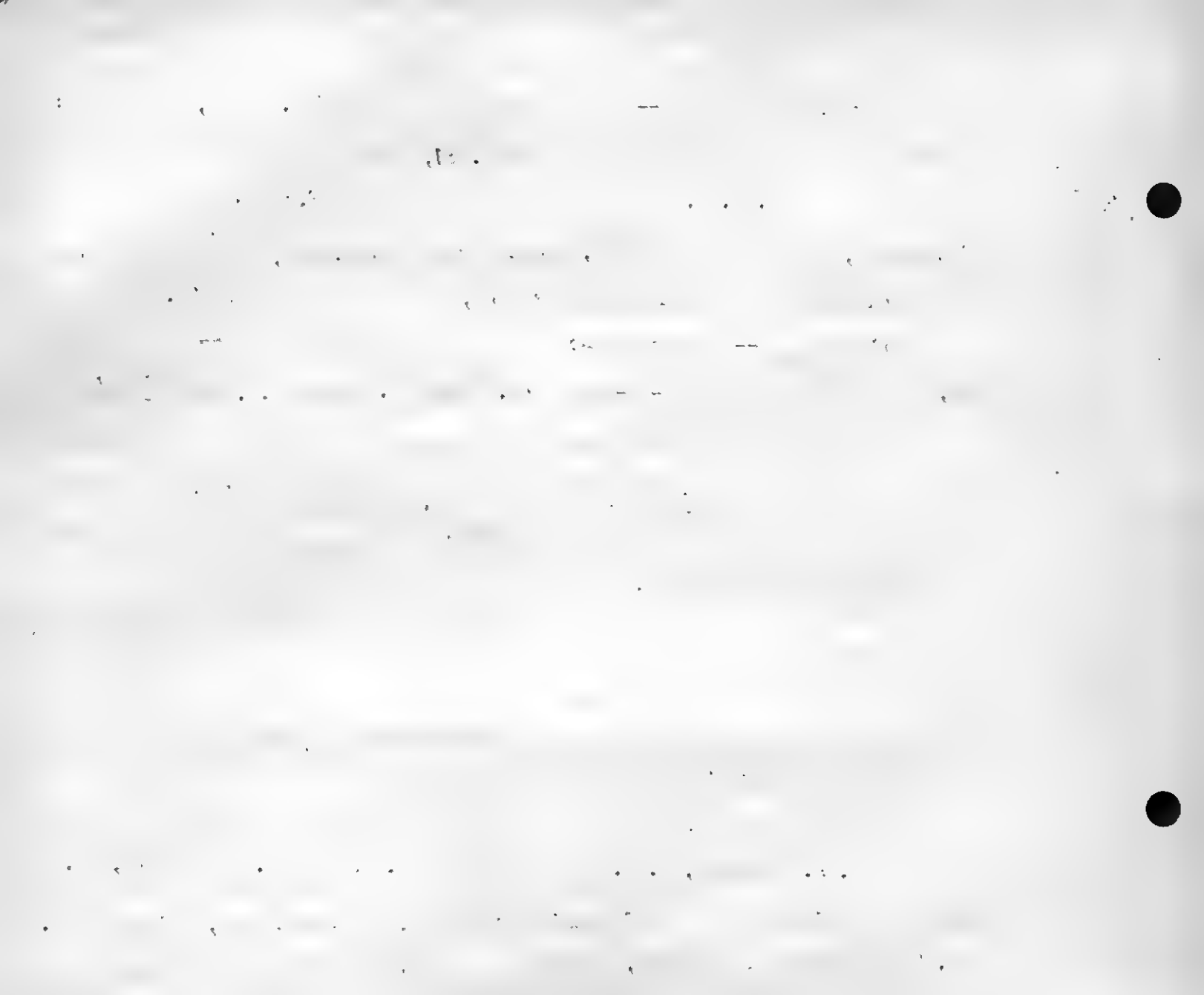


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bottom papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00093
CERTIFICATE OF DEATH

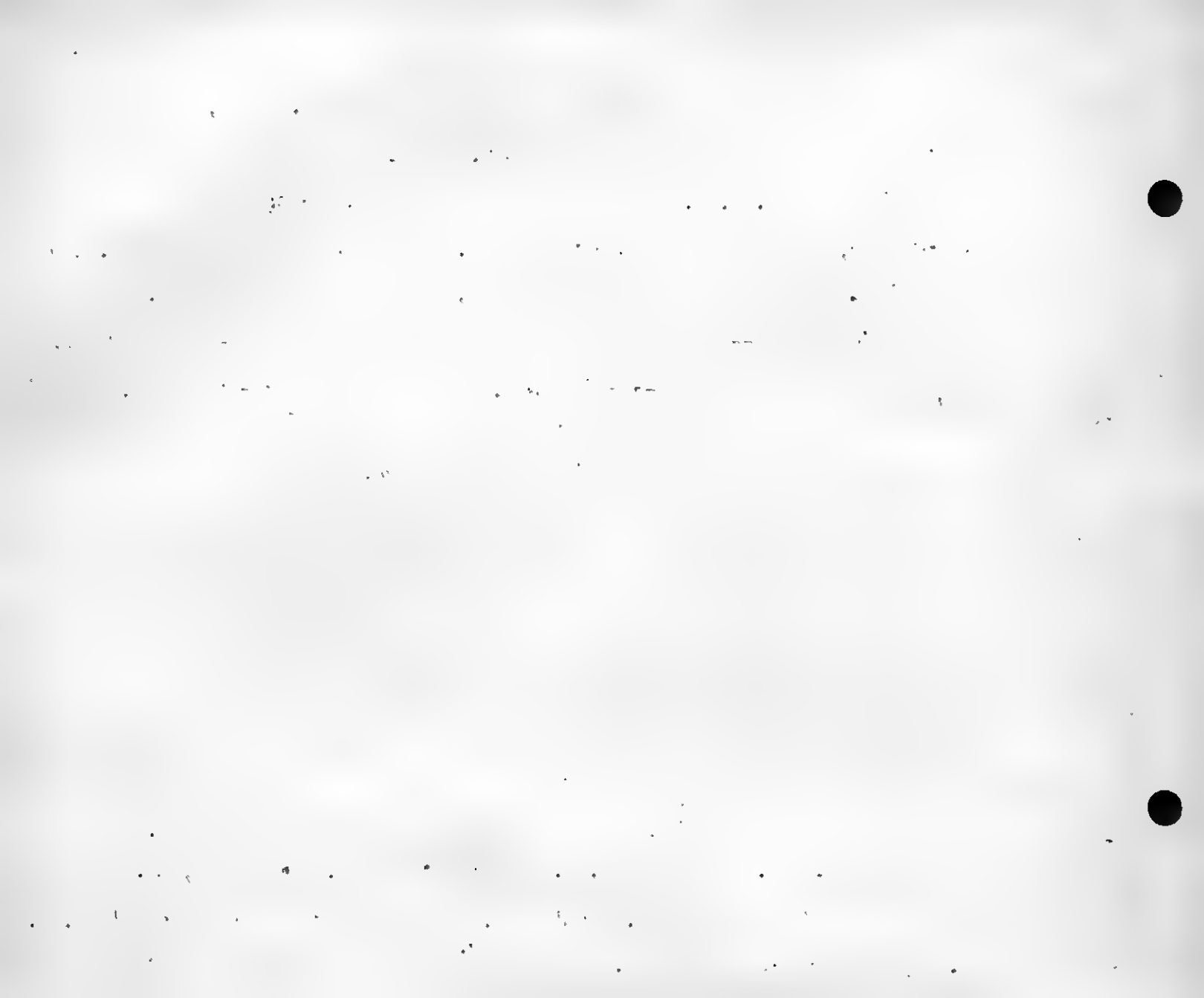
| | | | | | | |
|---|--|---|---|---|--------------------|--|
| 1. DECEASED NAME (Type or print) First Middle Last
Grace Vang | | | 2a. DATE OF DEATH
Jan. Month 18, Day 69 Year | | 2b. HOUR
8:20 P | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Jan. 31, 1886 | | 6. AGE (in years last birthday)
82 YRS. |
| 7a. BIRTHPLACE (State or foreign country)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Allegany Md. |
| 10. CITY OR TOWN OF DEATH
Cumberland, | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Cumb. Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife, | | 12b. KIND OF BUSINESS OR INDUSTRY
Own home |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Allegany | | 13c. CITY OR TOWN
Cumberland, | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 13e. STREET AND NUMBER
224 Schley St. | | 14. FATHER'S NAME First Middle Last
Frank Spaulding | | 15. MOTHER'S MAIDEN NAME First Middle Last
Alida Teeter | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16b. SOCIAL SECURITY NO.
220-44-3962 | | 17. INFORMANT Address
Mrs. Durand T. Becker P.O. Box 175 Eagle Pass Texas, 78852 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal bronchial pneumonia | | | | | | 1 week |
| 4124 DUE TO, OR AS A CONSEQUENCE OF
Arteriosclerotic cardiovascular disease with | | | | | | 5 years |
| (b) generalized arteriosclerosis, chronic. | | | | | | |
| (c) Chronic brain syndrome. | | | | | | 5 years. |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Latent depressed state. | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 7 October , 19 69 , to 18 January , 19 69 , that (I) (we) saw the deceased alive on 17 January , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
W. A. Van Ormer, M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | 22c. DATE SIGNED
20 January 1969 | | |
| 22d. PHYSICIAN'S NAME (Type)
W. A. Van Ormer, M. D. | | | | 22e. ADDRESS
122 So. Centre St. Cumberland, Md. | | |
| 23a. BURIAL, CREMATION, or other disposition
Burial | | 23b. DATE
1/22/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park, | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Allegany Md. |
| 24. FUNERAL DIRECTOR ADDRESS
H. Wayne George Cumberland, Maryland | | | | 25a. REC'D BY REGISTRAR
JAN 27 1969 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--|--|---|---|---|--|---|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First
Mary | Middle
Ann | Last
Webel | 2a. DATE OF DEATH
Jan. Month 7, Day 69 Year | | | 2b. HOUR
4:50 M |
| 3 SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Nov. 17, 1891 | | 6. AGE (In years last birthday)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
New York, | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Allegany Md | | | |
| 10. CITY OR TOWN OF DEATH
Cumberland, | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Memorial Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Clerk, | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. Store | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Allegany | | 13c. CITY OR TOWN
Cumberland, | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
699 Gephart Dr. |
| 14. FATHER'S NAME
First Middle Last
Richard -- Jones | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Mary -- Donovan | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No. | | | 16b. SOCIAL SECURITY NO.
111-30-4793 | | 17. INFORMANT
Address Springfield N.Y.
Mrs. Marie Hartnett 132-40 220 St. Gardens. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Long standing atherosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial infarction</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>within 24 hours</u> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building etc) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 4, 1969</u> to <u>Jan 7, 1969</u> , that (I) (we) lost the deceased alive on <u>Jan 7, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Blane M. Schindler, M.D.</u> DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
Jan. 8, 1969 | | |
| 22d. PHYSICIAN'S NAME (Type)
Blane M. Schindler, M.D. | | | | | 22e. ADDRESS
43 Greene St. Cumberland, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
1/11/69 | | 23c. NAME OF CEMETERY OR CREMATORY
St. John's Cem. | | 23d. LOCATION (City or Town) (County) (State)
Middle Village Queen's N. Y. | | | |
| 24. FUNERAL DIRECTOR
H. Wayne George 202 Greene St. Cumberland, Md. | | | | | 25a. REC'D BY REGISTRAR
JAN 10 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |



0009.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00095

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1969

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

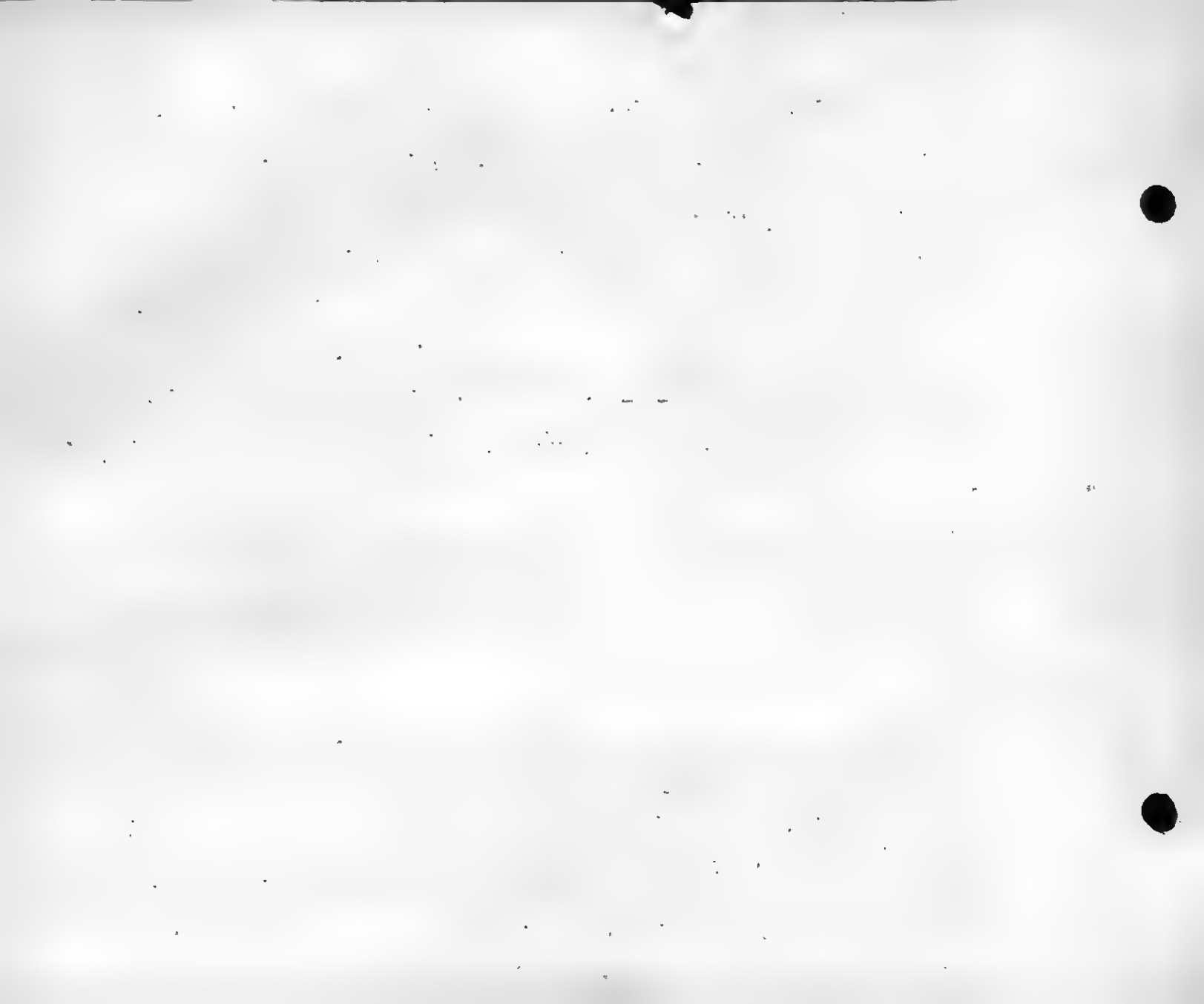
| | | | | | | | |
|--|--------|--|---|--|--|---|-----------|
| 1 DECEASED NAME
(Type or Print) | | First | Middle | Last | 2a DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> Month Day Year | | 2b HOUR |
| JANNIE | | | | WELLS | Jan. 4, 1969 | | 6:35 a.m. |
| 3. SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD | |
| Female | Negro | July 21, 1906 | | 62 YRS | | January 4, 1969 6:35 a.m. | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| South Carolina | | U.S.A. | | | | Allegany Md | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | |
| Cumberland | | | Memorial Hospital-DOA | | | None | |
| 13a USUAL RESIDENCE (Where deceased resided, if institut an residence before) | | 13b CITY OR TOWN | | 13c INSIDE CITY LIMITS? | | 13e STREET AND NUMBER | |
| South Carolina | | Florence | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 104 Kemp St. | |
| 14 FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | |
| Horace Lane | | | Roxanna Kelly | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | | 17. INFORMANT ADDRESS | |
| No | | | None Unk. | | | Arie Pickins Florence, South Carolina | |
| 18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
(b) CORONARY OCCLUSION
DUE TO, OR AS A CONSEQUENCE OF
(c) CORONARY SCLEROSIS
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
SUDDEN | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> January 4, 1969 | | | |
| | | | | ADDRESS (Street, city, town, or county) | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d. LOCAT ON (City or Town) (County) (State) | |
| Burial | | Jan. 8, 1969 | | Union Cemetery | | Florence, Florence, S. Car. | |
| 24 FUNERAL DIRECTOR ADDRESS | | | | 25a RECD BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| Philip B. Wendt 121 Memorial Ave. Cumb., Md. | | | | JAN 8 '69 | | <i>Philip B. Wendt</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|--|---|---|---|--|-------------------|--|--------------------------------------|---|--|-----------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or print) | | | First
ANNABELLE | | Middle
(BRODE) | | Last
WHETSTONE | | 2a. DATE OF DEATH
JANUARY 7, 1969 | | | 2b HOUR
M |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | | 5 DATE OF BIRTH
OCT. 15, 1899 | | | 6 AGE (in years last birthday)
69 YRS. | | 7 UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | 8 UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH
ALLEGANY Md. | | | | |
| 10 CITY OR TOWN OF DEATH
FROSTBURG | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
58 LINDEN STREET | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSE WIFE | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
MARYLAND | | | 13b COUNTY
ALLEGANY | | | 13c CITY OR TOWN
FROSTBURG | | 13d INSIDE CITY LIM-TSP
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
58 LINDEN STREET | | |
| 14 FATHER'S NAME
First Middle Last
PHILLIP BRODE | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
ELIZABETH SLEEMAN | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b SOCIAL SECURITY NO.
214-07-5362 | | | 17 INFORMANT Address
PETER G. WHETSTONE, FROSTBURG, MD. | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>arterio-sclerotic heart disease</u>
4123 DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 yrs. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-15</u> , 19 <u>65</u> , to <u>1-7</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1-4</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>H.C. Diehl M.D.</u> | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1-8-69 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>H.C. Diehl, M.D.</u> | | 22e. ADDRESS
<u>FROSTBURG, MD.</u> | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b DATE
JAN. 9, 1969 | | 23c NAME OF CEMETERY OR CREMATORY
F.B.G. MEMORIAL PARK | | | | 23d LOCATION (City or Town) (County) (State)
FROSTBURG, MD. | | | | |
| 24. FUNERAL DIRECTOR
JOSEPH R. DURST, FROSTBURG, MD. 21532 | | | | 25a. REC'D BY REGISTRAR
JAN 9 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>J. Chanley Judge</u> | | | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0009.

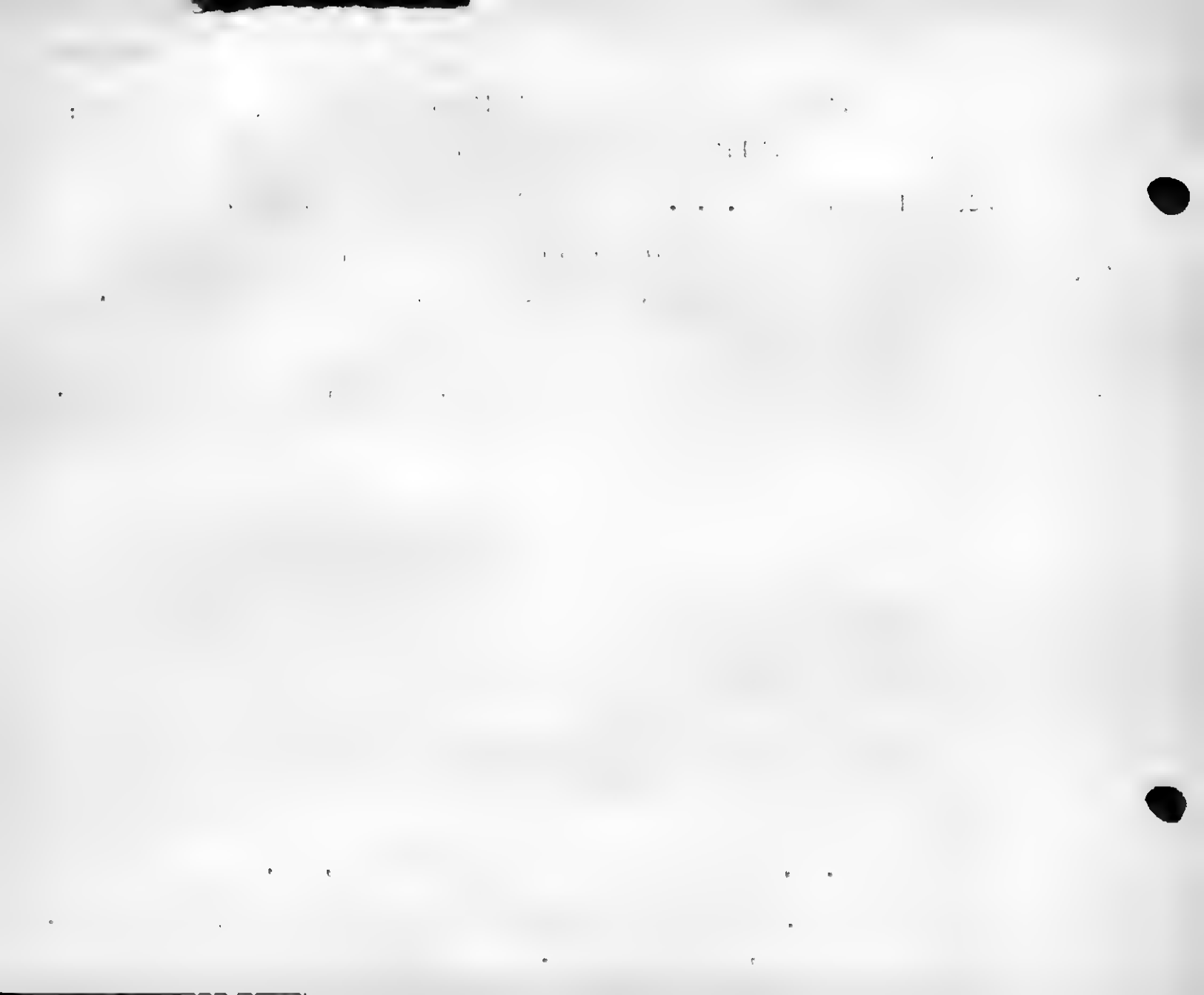
00097

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural, Rawlings | | c. LENGTH OF STAY IN lb
10yrs | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Route #1, Rawlings | | d. STREET ADDRESS
Route #1, Rawlings | |
| e. RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) John Wesley Whetzel | | 4. DATE OF DEATH
Month January Day 6th , Year 1969 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 4th, 1871 |
| 9. AGE (in years last birthday)
97 yrs | | F UNDER 1 YEAR
Months 12 Days 24 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Rt. Coal Miner | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Petersburg, W. Va. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Israel Whetzel | | 14. MOTHER'S MAIDEN NAME
Mary Jane Watts | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO
236-78-5335 | |
| 17. INFORMANT
Alvin O. Whetzel | | Address
Box 64, Keyser | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH CAUSED BY:
4109 IMMEDIATE CAUSE (a) CORONARY OCCLUSION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: ---
DUE TO (b) CORONARY SCLEROSIS
DUE TO (c) --- | | INTERVAL BETWEEN ONSET AND DEATH
SUDDEN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Benedict Skitarelic M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | Address (Street, city, town or county) Cumberland, Maryland | |
| 22. DATE SIGNED
1/6/1969 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
JAN 8, 1969 | 23c. NAME OF CEMETERY OR CREMATORY
Kalbaugh Cemetery | 23d. LOCATION (City or Town) (County) (State)
Elk Garden, WV |
| 24. FUNERAL DIRECTOR
Robert Kotanek, Keyser WV | 25a. REGISTRAR'S SIGNATURE
Charles Judge | | 25b. REC'D BY REGISTRAR
DATE JAN 8 1969 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|------------------------|---|--|---|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | |
| ISAAC | | | M | | WHISNER | Month 1 Day 23 Year 69 | | 7:15A M | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7. IF UNDER 1 YEAR | |
| MALE | | WHITE | | 3-1-78 | | 90 YRS | | MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| WEST VIRGINIA | | U.S.A. | | | | ALLEGANY Md | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| CUMBERLAND | | MEMORIAL HOSPITAL | | | | RETIRED Maintenance-Municipal | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | |
| MARYLAND | | ALLEGANY | | CUMBERLAND | | | | 16 POTOMAC ST. | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15 MOTHER'S MAIDEN NAME | | | First Middle Last |
| Isaac | | | Whisner | | | Julia | | | ? |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT Address | | | |
| no | | | | | | MEMORIAL HOSPITAL CUMBERLAND MD. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4122</u> <u>due to internal hemorrhage</u> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | |
| (b) <u>arterio-sclerotic heart disease</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 15, 1969</u> to <u>January 23, 1969</u> , that (I) (we) last saw the deceased alive on <u>January 2, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| <u>Dr. B. Schindler</u> | | | | | | | <u>1/24/69</u> | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| DR. B. SCHINDLER | | CUMBERLAND, MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | Jan. 25, 1969 | | Sunset Memorial Park | | Cumberland, Allegany, Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| James F. Scarpelli, Cumberland, Md. | | | | | JAN 27 1969 | | <u>Charles Judge</u> | | |



CERTIFICATE OF DEATH

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| | | | | | | | | | | |
|--|--------|------------------------------|--|---|-----------------------------------|--|---------------------------|------------------------|--------------------------------------|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month | | Day | Year | 2b. HOUR | |
| ROGER | | | C. | WILLISON | JANUARY | | 2 | 69 | 3:30 | |
| 3 SEX | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (in years
last birthday) | | IF UNDER 1 YEAR
MONTHS | | IF UNDER 24 HRS
HOURS | |
| MALE | WHITE | | 6-3-12 | | 38 | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| MD. | | USA | | | | ALLEGANY | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| CUMBERLAND | | | MEMORIAL HOSPITAL | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| MD. | | ALLEGANY | | CUMBERLAND | | | | YMCA 217 BALTIMORE ST. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| JOHN | | | WILLISON | | | ISORA | | | DRENNING | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | Address | | | | |
| yes | | NONE | | MEMORIAL HOSP. | | CUMBERLAND, MD. | | | | |

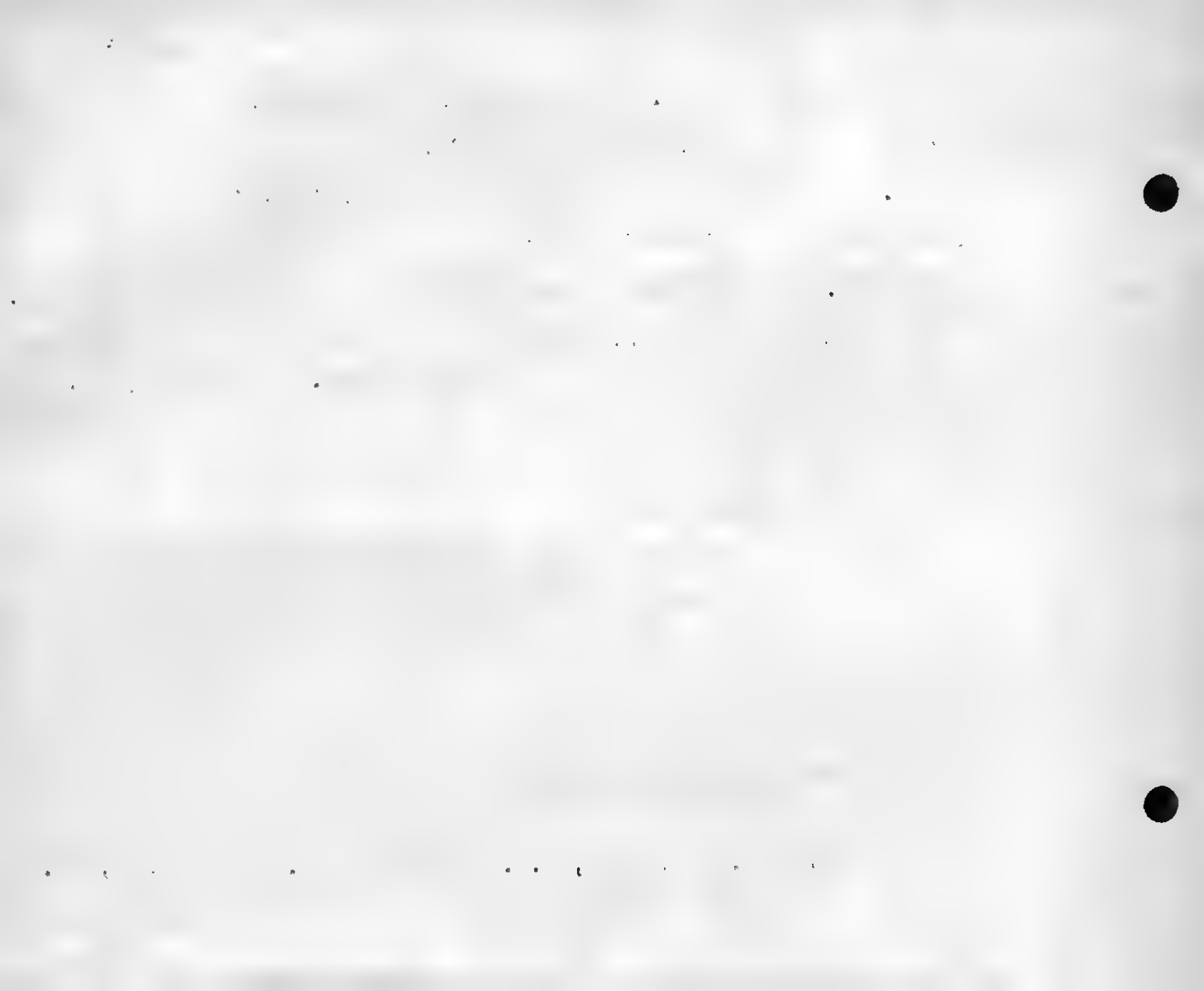
| | | | | | |
|---|--|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY | | | | | |
| IMMEDIATE CAUSE (a) <u>myocardial infarction</u> | | | | 3 days | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) _____ | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) _____ | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.) | |
| | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory,
office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 21, 1969</u> to <u>Jan 21, 1969</u> ; that (I) (we) last
saw the deceased alive on <u>Jan 21, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <u>Blane M. Schindler</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 1/21/69 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | |
| BLANE M. SCHINDLER, M.D. | | 43 GREENE ST., CUMBERLAND, MD. | | | |

| | | | |
|--|-----------|------------------------------------|---|
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
| Burial | 1/5/69 | Hellcrest Burial Ph. | Cumberland, Allegany Md. |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| Louis Stein Inc. Cumb. Md. | | DATE JAN 6 1969 | <u>Charles Judge</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MAILED
JAN 21 1969



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|---------|---|-----------------|---|--------------------------------|---|-----------------------|---|----------|
| 1 DECEASED NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | | |
| THORNTON | | | NMI | WILSON | 1 Month 14 Day 69 Year | | 6:30 PM | | |
| 3 SEX | 4. RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| MALE | WHITE | | 12-14-1909 | | 59 YRS. | | MONTHS DAYS HOURS MIN | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| MARYLAND | | USA | | | | ALLEGANY Md | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of workable week (last week)) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| CUMBERLAND | | SACRED HEART HOSPITAL | | RAILROAD machinist | | RR Helper | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY (M 15?) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | |
| MARYLAND | | ALLEGANY | | CUMBERLAND | | | | ROUTE 4 -OLDTOWN ROAD | |
| 14 FATHER'S NAME | | First | Middle | Last | 15 MOTHER'S MAIDEN NAME | | First | Middle | Last |
| SAMUEL | | | THORNTON | | ADELINE | | | TWIGG | THORNTON |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT | | 900 SETON DRIVE | | | |
| NO | | | | SACRED HEART HOSPITAL | | CUMBERLAND, MARYLAND | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY. | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Pulmonary edema bilateral</u> | | | | | | | | 12 hrs | |
| 5320 DUE TO, OR AS A CONSEQUENCE OF + | | | | | | | | | |
| (b) <u>Small bowel Infarction due to venous Thrombosis 4 days</u> | | | | | | | | 12 hrs | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) <u>Massive Gastrointestinal hemorrhage from duodenal ulcer</u> | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| None | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 1/13/69 | | Bleeding duodenal ulcer | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f LOCATION Street or R.F.D. No | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/13, 1969, to 1/14, 1969, that (I) (we) last saw the deceased alive on 1/14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE | | 22c DATE SIGNED | | 22e ADDRESS | | 22f REGISTRAR'S SIGNATURE | | | |
| Andrew Stasko MD | | 1/15/69 | | 401 DECATUR ST -CUMBERLAND, MD. 21502 | | Charles Judge | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 23a BURIAL, CREMATION (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| DR. ANDREW STASKO | | Burial | | Jan. 17, 1969 | | Hillcrest Burial Park | | Cumberland, Allegany, Md. | |
| 24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md. | | | | 25a. REC'D BY REGISTRAR JAN 20 1969 | | 25b. REGISTRAR'S SIGNATURE | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | |
|--|------------------------|--|--|--|--|---|---|--|
| 1 DECEASED NAME
(Type or Print) Sharon Marelene Wilt | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year 1-17-69 | | | 2b. HOUR 11:30 M | | |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
April 14, 1950 | 6 AGE (in years birthday) 18 YRS. | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS
HOURS <input type="checkbox"/> MIN <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD
Month 1-19-69 Day <input type="checkbox"/> Year 19 8:00a M | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Allegany Md | | |
| 10. CITY OR TOWN OF DEATH
Rural-Near Westernport | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of workweek (ie even that red.)
not employed | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland | | | 13b. COUNTY Allegany | 13c. CITY OR TOWN Westernport | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
214 Poplar St. | | |
| 14. FATHER'S NAME First Richard Middle Wilt Last Wilt | | | 15. MOTHER'S MAIDEN NAME First Margaret Middle Broadwater Last Broadwater | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | 16b. SOCIAL SECURITY NO
(If yes give war or dates of service) 212-54-8044 | | 17. INFORMANT
Evelyn Weicht | | ADDRESS
Everett, Pa. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxiation
873 X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Carbon Monoxide Poisoning
DUE TO, OR AS A CONSEQUENCE OF
(c) (Exhaust of Auto) | | | | | | | | About 2 Hrs.

" |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Exposure in near freezing temperature | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH About 11:30PM 1-17-69 | | | 21b. TIME OF INJURY Month, Day, Year
1-17-69 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
In parked car with engine running | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)
Road | | 21f. LOCATION Street or RFD No Mill run road near Westernport, Allegany, Maryland City or Town Allegany County Allegany State Maryland | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | JANUARY 19, 1969 | | |
| | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 21, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Tasker Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Cross Mineral W. Va. | | |
| 24. FUNERAL DIRECTOR
L. Boal | | | | ADDRESS
Westernport, Md. | | 25a. REC'D BY REGISTRAR
JAN 22 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge |



FOR STATE HEALTH DEPT.

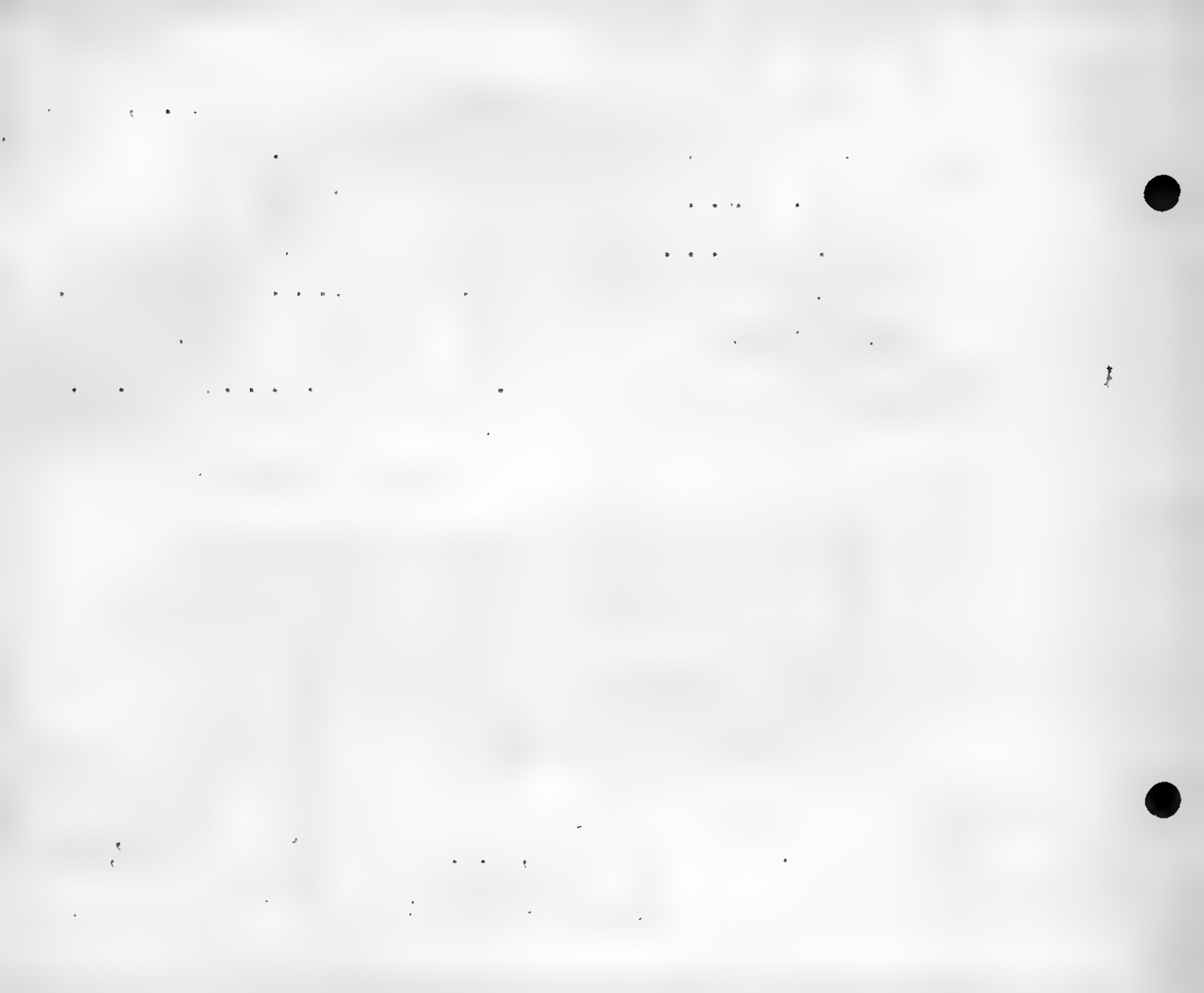
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 5 Film 3008
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
1/17/67 00102 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00102

| | | | | | | | |
|--|--------|---|--------------------------------|---|---|---|---|
| 1 DECEASED-NAME
(Type or Print) | | First | Middle | Last | 2a DATE KNOWN OF DEATH
ESTIMATED <input type="checkbox"/> Month Day Year | | 2b HOUR |
| Loretta | | | | Windemuth | Jan. 9, 1969 | | 8:05M |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (in years last birthday) | 7 UNDER 24 HRS
MONTHS DAYS HOURS MIN. | 2c DATE PRONOUNCED DEAD
Month Day Year | | 2d HOUR |
| Female | White | Jan. 17, 1969 | 78 YRS | | Jan. 9, 1969 | | 8:05M |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Cumberland Md. | | U.S.A. | | | | Allegany Md | |
| 10. CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Cumberland Md. | | D.O.A. Memorial Hospital | | Housewife. | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY, LIM 15? | |
| Maryland | | Allegany | | Cumberland. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME First Middle Last | | 15 MOTHER'S M.A.D.E.N NAME First Middle Last | | | | | |
| George Windemuth | | Elizabeth Anna Mudge. | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT ADDRESS | | | |
| No | | | | Mrs. Albert Klavuhn. R.F.D. #5 Cumb. Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | APPROX. MAT. INTERVA. BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | | | SUDDEN |
| 4109 CORONARY OCCLUSION | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| (b) CORONARY SCLEROSIS | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b TIME OF INJURY Month, Day, Year | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| | | 19 P.M. | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town County State | |
| | | | | | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | | 22b DATE SIGNED | | | |
| Benedict Skitarellic | | <input type="checkbox"/> | | Jan 9, 1969 | | | |
| EXAMINER'S NAME (Type) | | BENEDICT SKITARELIC, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | CUMBERLAND, MARYLAND | |
| 23a BURIAL, CREMATION REMOVAL (Specify) | | 23b DATE | | 23c NAME OF TRASTRY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | |
| Burial | | 1/12/69 | | St. Luke's Cem. | | Cumberland Allegany Md | |
| 24 FUNERAL DIRECTOR | | ADDRESS | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| Louis Stein Inc. | | Cumb. Md. | | DATE JAN 13 1969 | | H. Clements | |



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 2 Film 408

1/17/69 kl

00103

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00103

| | | | | | |
|--|-------------------------|---|--|---|--|
| 1. DECEASED-NAME
(Type or Print) Rose May Wolford | | | 2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI-
DEATH MATED <input type="checkbox"/> Jan. 2 19 69 7 am | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
Aug. 5, 1890 | 6. AGE (In years
last birthday)
78 YRS | IF UNDER 1 YEAR
MONTHS 78 DAYS 78 | IF UNDER 24 HRS.
HOURS 78 MIN. 78 |
| 7a. BIRTHPLACE (State or foreign
country) West Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Cumberland | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) Memorial Hosp | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE West Va. COUNTY Hampshire CITY OR TOWN Augusta | | | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME John W. Hott | | | 15. MOTHER'S MAIDEN NAME Jermina (Hott) Hott | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) no | | | 16b. SOCIAL SECURITY NO. 214-52-1825 | | |
| 17. INFORMANT Elmer Wolford | | | ADDRESS Augusta, West Va. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SHOCK
5339 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. } (b) EXANGUINATION
(c) PEPTIC ULCER | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 HOUR |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
5400 | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | |
| 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL
SIGNATURE Benedict Skitarelic | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | |
| EXAMINER'S
NAME (Type) BENEDICT SKITARELIC, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | January 2, 1969 | |
| ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | Jan. 5, 1969 | | Malick Cemetery | |
| 24. FUNERAL DIRECTOR
Wade L. McKee | | ADDRESS
Augusta, W Va | | 25a. REC'D BY REGISTRAR
DATE JAN 6 1969 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|--|---|---|---|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| MILORED | | | Martha | | | WORKMAN | | 1 Month 28 Day 89 12:35 | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. IF UNDER 1 YEAR | | |
| FEMALE | | WHITE | | Apr. 24, 1894 | | 74 | | 9 MONTHS 2 DAYS | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| MARYLAND | | U.S.A. | | | | ALLEGANY | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| CUMBERLAND | | | MEMORIAL HOSPITAL | | | House Wife | | Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| W. VIRGINIA | | | | | KEYSER | | | | 50 N. MAIN ST. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| FULLER | | | BARNARD, Sr. | | | ADA Cannon ATKINS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| No | | | None | | Memorial Hospital | | CUMBERLAND, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Carcinomatosis with Brain metastases</u> | | | | | | | | | 6 months | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) <u>Adeno-carcinoma, hepatic flexure Colon,</u> | | | | | | | | | 13 months | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | | |
| | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2 pm</u> , 19 <u>69</u> , to <u>2:00 pm</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>26 Jan.</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| W.A. VanOrmer, M.D. | | | | | | | | | 1-27-69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | | |
| W.A. VanOrmer M.D. | | | | | CUMBERLAND, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | Jan. 29, 69 | | Queens Point Cem. | | Keyser Mineral W.Va. | | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Harold W. McKenzie | | | | | Keyser, W.Va. | | JAN 31 1969 | | | |

10101

25:00 05 30

WORKMAN

MILORRE

73 19 2

4-24-92

WHITE

FEMALE

ALLEGANY

U.S.A.

CARYLANN

one

Room 14

MEMORIAL HOSPITAL

CUMBERLAND

50 N. MAIN ST.

X

KEYSER

W. VIRGINIA

47/115

ADA Room

BADNARD

EUGEN

MEMORIAL HOSPITAL CUMBERLAND, MD.

MEMORIAL HOSPITAL

Room

To

O

1-27-92

CUMBERLAND, MD.

DR. A. J. WILKIN

Keyser, W. Va. Green Editor

Jan 26, 92

Editor

JAN 27

Keyser, W. Va.